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Resident Physician

JOURNAL FOR THE HOSPITAL STAFF OFFICER

JULY 1959
Vol. 5, No. 7

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JUL 30 1959

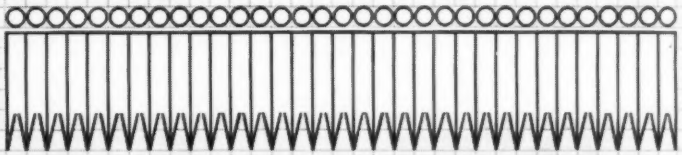
MY THREE YEARS IN GROUP PRACTICE p. 46

- MILITARY SERVICE NOW OR DEFERMENT FOR RESIDENCY TRAINING?
- THE TRAINING OF THE PSYCHIATRIST

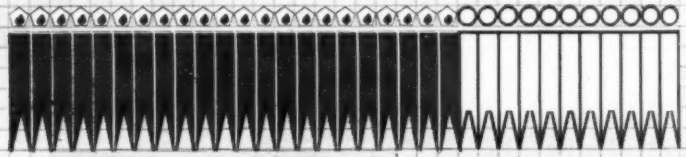
Decadron

DEXAMETHASONE

treats more patients more effectively...



Of 45 arthritic patients
who were refractory
to other corticosteroids*



22 were successfully
treated with **Decadron**[1,2]

1. Boland, E.W., and Headley, N.E.: Paper read before the Am. Rheum. Assoc., San Francisco, Calif., June 21, 1958.
2. Bunim, J.J., et al.: Paper read before the Am. Rheum. Assoc., San Francisco, Calif., June 21, 1958.

*Cortisone, prednisone and prednisolone.

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Additional information on DECADRON is available to physicians on request.

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Resident Physician

July 1959, Vol. 5, No. 7

Articles

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In the menopause numerous measures are available to help alleviate the symptoms—but only estrogen treats the basic deficiency.

Shelton, E..K.: J. Am. Geriatrics Soc. 2:632 (Oct.) 1954.

Hot flushes, palpitations, and other vasomotor symptoms of the menopausal syndrome are easily related to declining ovarian secretion. Not so the multiplicity of other symptoms which may appear long before, or even years after menstruation ceases, such as headache, insomnia, irritability, and fatigability; and the musculoskeletal symptoms ranging from vague pains, arthralgias and myalgias to postmenopausal osteoporosis. In either case, the cause is the same: estrogen deficiency.

Estrogen replacement is specific therapy.

Estrogen replacement therapy specifically treats the basic deficiency. It stabilizes the vasomotor system enabling the patient to readjust to a new physiologic environment. Furthermore, estrogen is not just a "female sex hormone." It has a beneficial effect on bone and on protein metabolism;[1] on uterine supporting structures;[2] on the skin, and the mucosa—not only of the vaginal tract but also of the urinary bladder and stomach.[3–5] Estrogen provides a possible relative immunity to coronary atherosclerosis,[6] and helps to counterbalance the tendency to adrenal and pituitary hyperactivity.[7]

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"Premarin" not only promptly relieves the hot flushes and the other distressing menopausal symptoms but almost invariably imparts a gratifying sense of "well-being." In addition, the over-all influence of "Premarin" on metabolic functions is also increasingly recognized as a decisive factor in the postmenopausal years to insure better physical health and greater emotional stability.[8–10] These are some of the important features that have established clinical acceptance for "Premarin" over more than seventeen years, and have made it the most widely prescribed natural oral estrogen in the menopause.

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1. Stein, I., Stein, R.O., and Beller, M.L.: Living Bone in Health and Disease, Philadelphia, J.B. Lippincott Company, 1955, chap. 9, p. 176. 2. Anderson, H.E.: J.A.M.A. *168*:173 (Sept. 13) 1958. 3. Goldzieher, M.A.: Geriatrics *1*:226 (May-June) 1946. 4. Hamblen, E.C., in Stieglitz, E.J.: Geriatric Medicine, ed. 2, Philadelphia, W.B. Saunders Company, 1949, chap. 41, pp. 657-673. 5. Kurzrok, L.: (Correspondence), Mod. Med. 26:33 (Oct. 1) 1958. 6. Rivin, A.U., and Dimitroff, S.P.: Circulation 9:533 (Apr.) 1954. 7. Griffith, G.C.: Obst. & Gynec. *7*:479 (May) 1956. 8. Stoddard, F.J.: Obst. & Gynec. Surv. *10*:801 (Dec.) 1955. 9. Shelton, E.K.: J. Am. Geriatrics Soc. 2:627 (Oct.) 1954. 10. Randall, C.L., Birtch, P.K., and Harkins, J.L.: Am. J. Obst. & Gynec. *74*:719 (Oct.) 1957.

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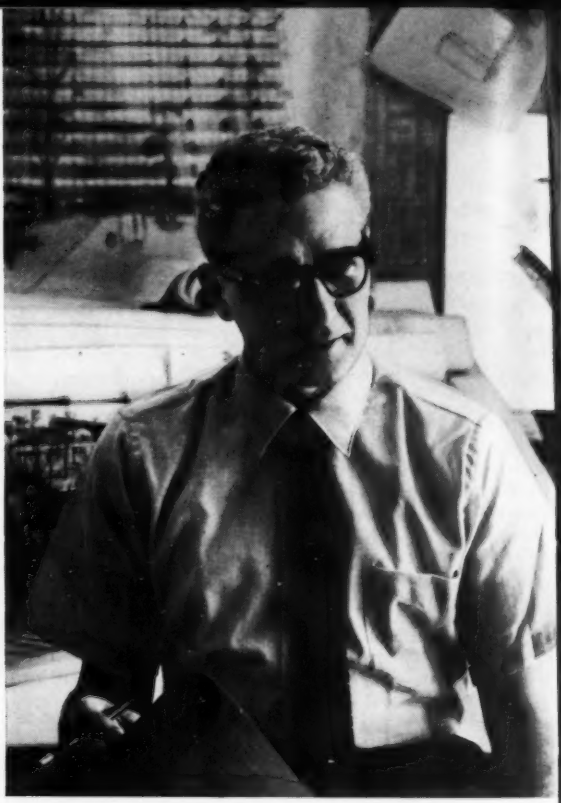

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July 1959, Vol. 5, No. 7

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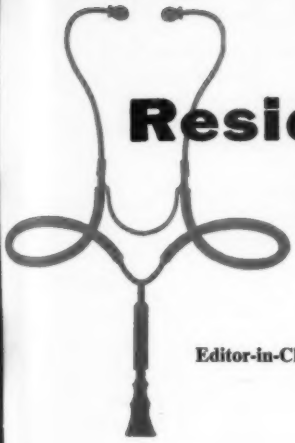
July

Journal for the Hospital Staff Officer



Resident Physician

July 1959, Vol. 5, No. 7

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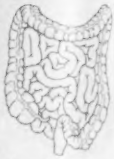

bowel surgery

*Goodman, L. S., and Gilman, A.: The Pharmacological Basis of Therapeutics, Ed. 2, The Macmillan Company, 1955, p. 1312.

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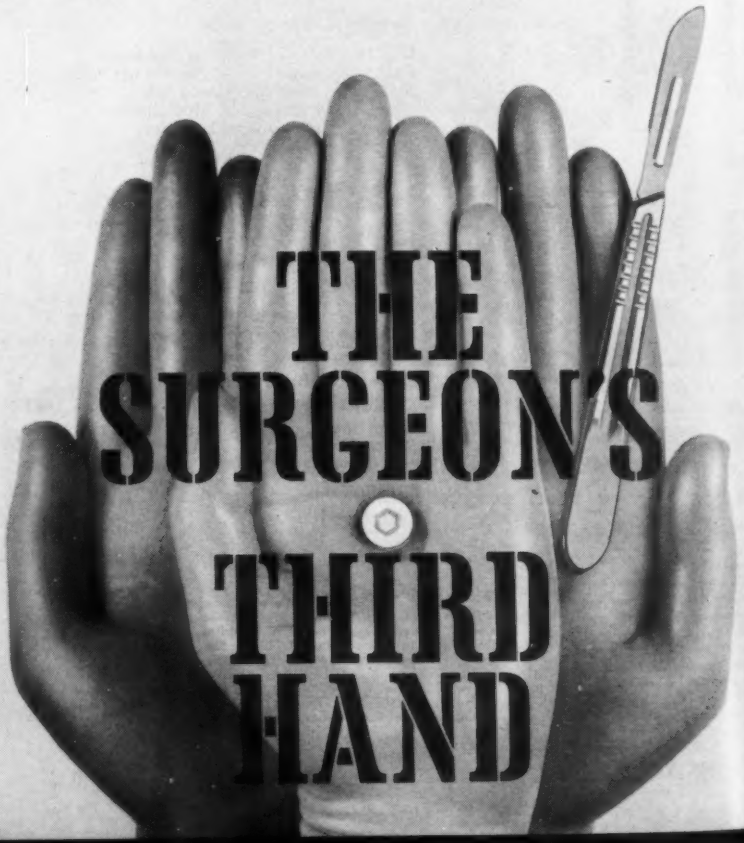

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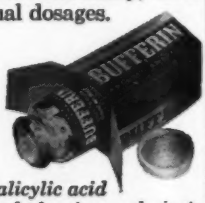

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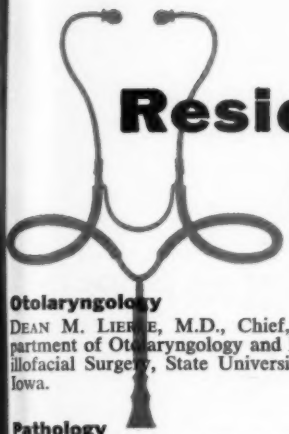

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Therapeutic Reference

The following index contains all the products advertised in this issue. Each product has been listed under the heading describing its major function. By referring to the pages listed, the reader can obtain more complete information. All products are registered trademarks, except those with an asterisk.(*).

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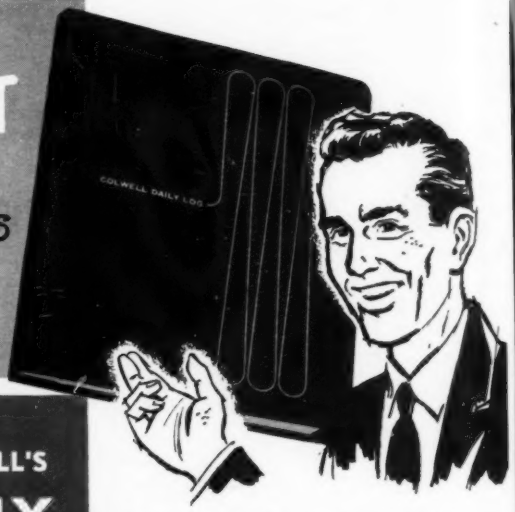

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[1]Thornton, Madeline J., The Use of Vaginal Tampons for the Absorption of Menstrual Discharge. Am. Journal of Ob. & Gyn. 46:259-265

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*tran-qui-lax-ant (tran'kwi-lak'sant) [< L. *tranquillus*, quiet; L. *laxare*, to loosen, as the muscles]

Letters to the Editor

Unsigned letters will neither be published nor read. However, at your request, your name will be withheld.

Understanding

Language problems again! There are two ways to look at it. It always takes two for a conversation, one who does the talking, and the one who does the listening. At least it should be that way.

In 1955 to 1956, 6033 foreign, nonimmigrant doctors were working in American hospitals. The exchange visitors came from 84 different countries. Many knew English only by learning it in school. Yet there is only one way to really learn a language: practice!

The patient knows how difficult it can be to give his history to a foreign doctor, how difficult it is to understand the American language when spoken with a German, Mexican, Turkish or Japanese pronunciation. It takes a lot of effort and patience to deal with these problems, especially if you're sick and want to be helped.

I have been a foreign doctor at a hospital in Portland, Oregon and must say I was very impressed by the understanding we foreign interns found with this problem from the patients as well as from our colleague doctors. All the patients I came in contact with tried to understand my horrible English and encouraged me with a friendly "You're doing fine!" or,. "You are improving more every day." And the American doctors always helped me too. They enjoyed teaching me their language and their slang. I found it to be a lot of fun. I felt at home from the first day. I think the other foreign residents,

—Continued on page 25

—Continued from page 22

Mexican, Filipino or Latvian can agree to my experience. Besides the language, I think the foreign doctors learned that the Americans are broad minded and open hearted.

By this little letter, I wanted to thank all of you, patients as well as colleague doctors for your understanding and help.

Freidrich Schreiner, M.D.
Burghausen/obb, Germany

Words

In your February 1959 issue "Key Words for the Clinic: How to Speak Yiddish," small pox was translated as *steln pocken.* To this resident the above translation seems incorrect. Small pox in Yiddish is simply *pocken* while *steln pocken* means to vaccinate.

Josua Sack, M.D.
Veterans Administration Hospital
Coral Gables, Florida

National Boards & ECFMG

• *The following exchange of letters is published because of its interest to foreign graduates.*

As a foreign medical graduate who came as an immigrant for permanent residence in the U.S.A., I have recently taken the American Medical Qualification

—Continued on page 27

new psychoactive agent
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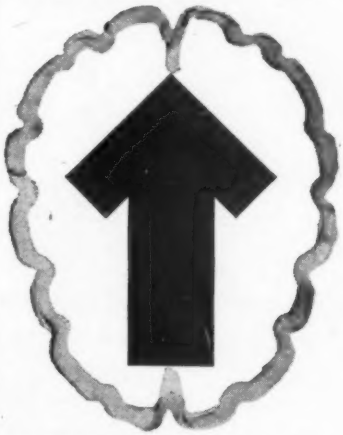
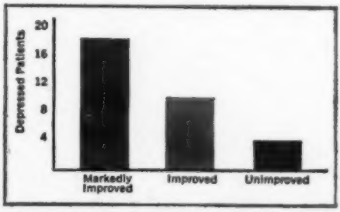
β-phenylisopropyl hydrazine supplied as the hydrochloride



Revitalizes depressed patients—elevates mood, increases alertness and ability to maintain work and social adjustment.[1,2]



1. Agin, H. V.: In A Pharmacologic Approach to the Study of the Mind, Springfield, Ill., Charles C Thomas, in press.
2. Agin, H. V.: Conference on Amine Oxidase Inhibitors, New York Academy of Sciences, Nov. 20-22, 1958.

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even if your patient is a boom rat

*logger who rafts logs in a "boom"

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TYLENOL® (Acetaminophen) ..... 300 mg.
The best-tolerated analgesic for painful musculoskeletal disorders

Dosage: Two tablets t.i.d. or q.i.d.

Supplied: Tablets, scored, pink, bottles of 50

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—Continued from page 25

Examination held by the Educational Council for Foreign Medical Graduates.

Fully aware of the following facts:

1. The National Board Examinations are rather limited to approved American and Canadian Medical School Students or Graduates.

2. Upon request of a State Board of Medical Examiners a foreign Medical graduate may be asked to pass the National Board Examinations as a prerequisite for admission to the Medical Examinations of that particular State Board.

I feel that the National Board of Medical Examiners would not hesitate to let a foreign medical graduate like me take the National Board Examinations and so put an applicant to a licensing body in the U.S.A. in a better position.

As the questions of the American Medical Qualification Examination are being selected from the large pool of questions of the National Board of Medical Examinations I think that extending the potentialities of the National Board of Medical Examiners to

—Concluded on page 29

new psychoactive agent

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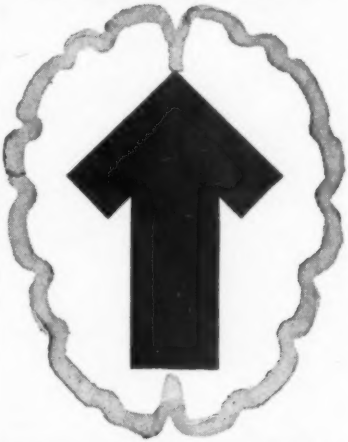
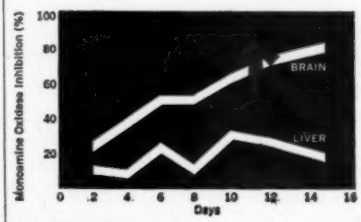
β-phenylisopropyl hydrazine supplied as the hydrochloride



Brightens mood, dispels apathy, melancholy, social withdrawal through selective suppression of monoamine oxidase (MAO) of brain at doses which have little or no effect on liver.



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SUMMIT, NEW JERS

—Concluded from page 27

include successful graduates of the A.M.Q. Examination would be deeply appreciated by a large number of foreign medical graduates among whom are American born, too.

I would deeply appreciate your advising me as to the necessary steps as I feel am able to take the National Board Examinations.

Name withheld at
writer's request

Answer:

At the present time, the National Board does not admit to its examinations graduates of medical schools outside of the United States and Canada. Therefore, the fact that a foreign graduate has passed the examinations of the Educational Council does not allow him to be admitted to National Board examinations. Perhaps at a future date there will be a change in this regard, but this is not the case at the present time. May I suggest that you keep this possibility in mind so that you will be aware of any future happenings.

Eleanor Mozenter
Secretary to Dr. Hubbard
National Board of
Medical Examiners
Philadelphia, Pennsylvania

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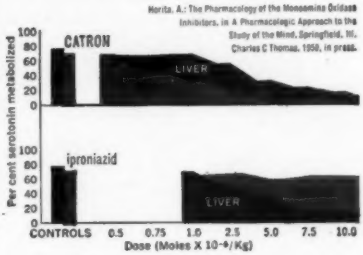

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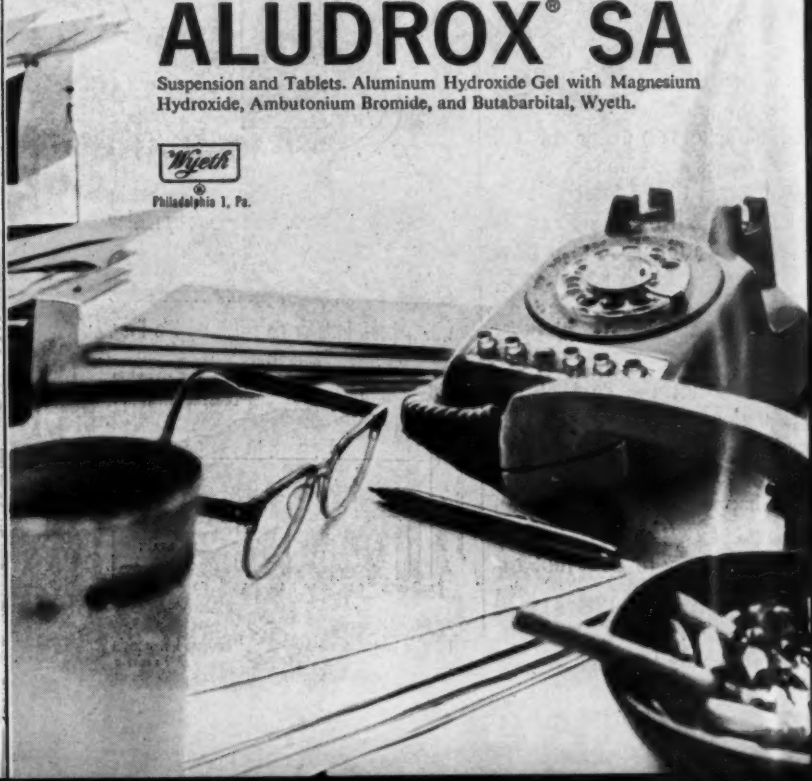
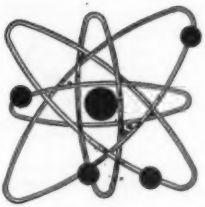


Viewbox Diagnosis

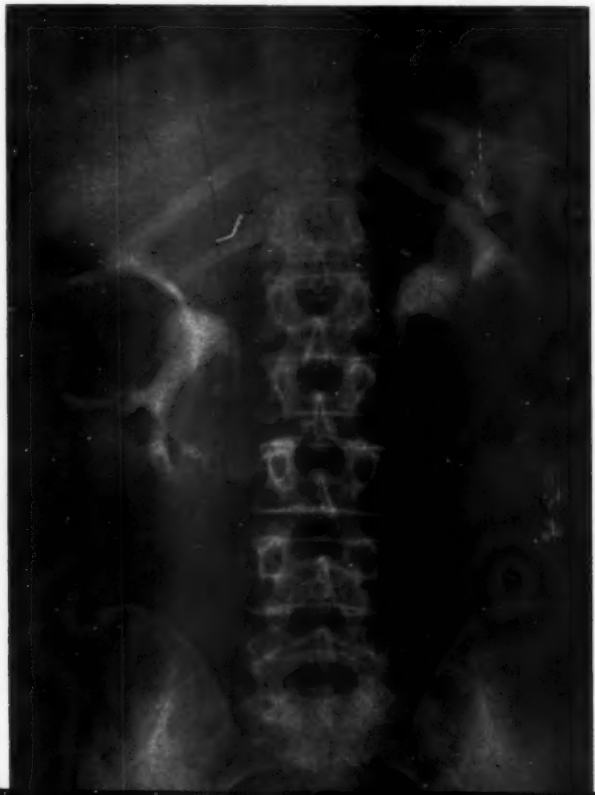
Edited by Maxwell H. Poppel, M.D., F.A.C.R.,
Professor of Radiology, New York University College of Medicine
and Director of Radiology, Bellevue Hospital Center



Which Is Your Diagnosis?

1. Normal
2. Hydronephrosis
3. Tumor of kidney
4. Polycystic disease

(Answer on page 123)



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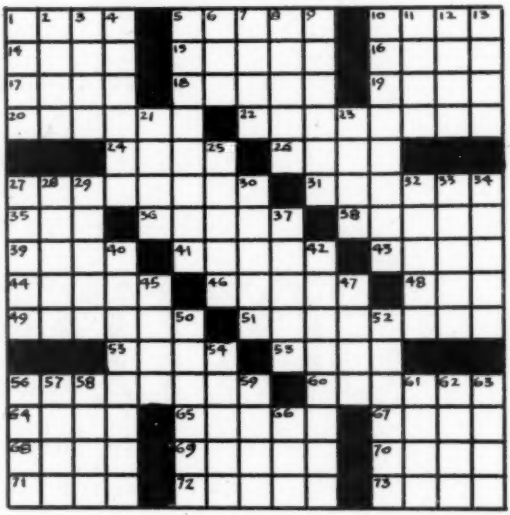
(Answer on Page 123)



ACROSS

1. Cohesive mixture
5. Threadlike
10. Gaunt
14. Nervous malady, marked by murderous frenzy
15. Not smooth
16. City in Nevada
17. Calcium oxide
18. Looplike structure (pl.)
19. Second cervical vertebra
20. Acid used for treating pyocyanosis
22. Amputate
24. Animal enclosure
26. Foul matter
27. For bathing (pl.)
31. Starch soluble in water
35. Chemical suffix indicating quinquivalent nitrogen
36. Odor
38. Carried
39. A number
41. Clyster
43. Neon, oxygen, phosphorus (symbols)
44. Choice
46. Chemical suffix indicating bivalent hydrocarbon radical
48. American Medical Association
49. Seek
51. Pertaining to amnesia
53. Toward the mouth
55. A branch, as of a nerve (pl.)
56. Artificial teeth
60. Thickening of the skin
64. Oil (comb. form)
65. Around (prefix)
67. Platinum loop
68. Soothing medicine
69. Begot
70. Tubular passage
71. Solely
72. Inflammation of the eyelid (pl.)
73. Prescribed portion of a medicine

DOWN

1. Cheek bone
2. Derived from ammonia
3. Indefinite quantity
4. Preliminary drawing
5. Break in a bone
6. Electrified particle
7. Sensuous desire
8. Solidifying agent in culture mediums (pl.)
9. Any catarrhal discharge
10. Act of pulling
11. Six (prefix)
12. Initial (abbr.)
13. Organ of smell
21. Very small quantity
23. Insensible
25. Black wood
27. Osseous framework
28. Like an old woman
29. Tapeworm
30. Perceive by scent
32. Gloomy
33. Fibrous tumor
34. Himalayan city
37. Mohammedan prince
40. Pelvic section
42. Substances that counteract acidity
45. Pale brown
47. Electron, hydrogen, masurium (symbols)
50. Annoy
52. Having a coiled appearance
54. Abdicate
56. Deuterium, oxygen bohemium (symbols)
57. Ardor
58. Girl's name
59. Nimble
61. Mother of Apollo
62. Employs
63. Withered
66. Helium, electron (symbols)

The more pote

the greater the need f

Physiologic Balance

start . . . alternate . . . termina

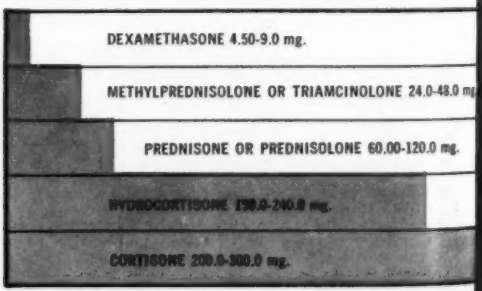
with potent, long-acting, intramuscular

Cortrophin

the specific, physiologic adrenocortical stimulant

Balance corticosteroid therapy with Cortrophin-Zinc

After every 6 days' SYSTEMIC THERAPY WITH:



On the 7th day OMIT THE CORTICOSTEROID AND INJ
CORTROPHIN-ZINC, 40 U.S.P. UNITS,

Perrin H. Long, M.D.

Editor's Page

"What Shall I Do?"

This issue of your Journal presents a discussion on the question: "Military Service Now, or Deferment for Residency Training?" (please see page 89) which was prepared in the Office of the Assistant Secretary of Defense For Health and Medical. We hope this article will help our resident and intern readers understand how the "Berry Plan" for military service relates to their futures.

By the time you read this, you should have received (or will receive very shortly) documents dealing with the "Armed Forces Reserve Medical Officers Commissioning and Residency Consideration Program—A Plan for Residency Deferment," as the Berry program is officially called. If an *intern* has *not* received these documents by 1 August 1959, he should write to Dr. Frank B. Berry, Asst. Secy. of Defense (Health and Medical), The Pentagon, Washington 25, D. C.

The first thing an intern should do when he receives these documents is to read over *very, very carefully* the Information Bulletin. If there are parts which appear unclear to him he should write directly to Dr. Berry requesting clarification. At this stage of his thinking, direct communication with Dr. Berry's office is desirable, rather

than having the intern's inquiry directed to a nearby Army, Navy, or Air Force installation.

What are the pros and cons of the three options offered under the Plan? Your Editor has given much thought to the Berry Plan since it was first introduced some five years ago, as to how it affected both the military medical service and civilian medicine. In thinking of the latter, we were concerned with its effects on our own residency educational program. It would be our opinion that all directors of residency programs would prefer to have their residents deferred for their full period of residency training, or to have residents who have completed their military medical obligations. Certainly, it disturbed their programs (and a lot of residents) a few years ago when eligible residents were ordered into service almost at mid-year. Directors of programs, and residents themselves don't want to have this happen again if they can avoid it.

But one might ask, "Why not be deferred for one year and then go into the service?" The individual who has had one year of residency won't get a better assignment in the Services, and actually he is just putting off what he knows he has to face. Our feeling has consistently been that if the intern does not get deferred for full residency training, he had best get his military service obligations off as soon as possible. Also, evidence is accumulating from chiefs of service in various parts of the country that physicians who have completed their obligated medical service are definitely more mature. They not only carry out their patient responsibilities more efficiently, but also seem to get more out of residency training than those physicians who enter such training immediately after their internship. In other words, they have "grown up."

But any intern might raise this question: "The article states that only 1800 of the 6000 eligible interns will go into service on or after 1 July 1960. Why not play it smart

and take my chance on being drafted? That chance is less than one in three, and I may never even have to go into the service." To this your Editor would answer: "You have correctly figured the angles and the chances, but someone has to provide medical care for the millions of men in the armed forces and their dependents in many areas of the world. If you don't help out, someone else will have to do it for you." If I were figuring the angles and the chances that closely, I would have a hard time living with myself, because I would be too ashamed of my behavior, and I would have a hard time facing my colleagues who had signed up for the "Plan." I can't explain this attitude, except that it is the way I know from experience, I would feel. Call it patriotism or what you will, but I have always felt that I owe my country and my government a great deal, and I have always been looking for ways to repay my debt. Now, as our country has been just as good to you as it has been to me (and maybe better), it has been difficult for me to understand the attitude of those who don't sign up in the Berry Plan.

Furthermore, I feel very certain that if the "cold war" heats up and a selective service draft of doctors is asked for by the military services, this will be put into effect promptly, and there will be no delays in induction, or deferments. The Berry Plan has had the backing of organized medicine almost since its inception. It is a fair and square program. Our countrymen who are serving with the military forces at home and abroad, and their dependents, must receive the American type of medical care. Despite what critics may say about draft discrimination against doctors and dentists, it is one of the duties of young physicians in this country to provide at least a part of this care for our fellow countrymen and their dependents. So, if you ask me, my answer will be, 'Sign up with the Berry Plan."

MY THREE YEARS IN G

This young surgeon knew little about group practice when he became the fourth man in an established group. But that was three years ago, and he's learned a lot since then. Here's his frank appraisal of his experience.

What can you expect from a group practice, professionally and economically? What are its advantages and disadvantages?

Three years ago these were all-important questions to me, for I had decided to join a group. Though I got advice from older doctors and read a number of journal articles about groups, I realized that there were some questions only experience can answer.

Perhaps some of the things I learned may prove of value to you who are finishing up residencies and looking forward to that big step into private practice.

My experience may not be typical, for ours is small as groups go, not one of those highly organized clinics that you read so much about. Articles dealing with such large groups were all I could find when I tried to bone up on the subject. At that time I was fresh out of the army, a board certified surgeon eager to try my hand at private practice.

Trial period

From a friend I learned that this particular group was looking for a surgeon and I went for an interview. I liked what I saw and we mutually agreed to a six months' trial. If I wasn't happy with the setup at the end of that

In Group Practice

William Gordon, M.D.

period I could simply walk out. And if my colleagues were dissatisfied with me or my work, well, that was it. I think such agreements are pretty much the rule for a new man joining a group.

The trial period proved valuable to me. It gave me answers to a number of questions and put me on firm ground when it came time to sign a contract. But more about that later.

Our group is located in a town along the eastern seaboard. It's about 100 miles from New York City, in an area of farms, villages and large summer estates. The summer residents and vacationers make the months from July to September our busiest time. But things are never really slow any time of the year.

Before I joined, the group was composed of three men: a board internist, a GP who specialized in ob-gyn, and another GP. They had been together as a group for about ten years.

Facilities

Our medical building is in the center of town, a sprawling converted residence. There is a large waiting room, a private consultation room for each man, three treatment rooms, an x-ray room, a small darkroom, and a lab. One day a week we have the services of a radiologist. He does the complex x-ray procedures and provides written reports on all films we do not feel competent to evaluate.

So that the group discussed in this article cannot be identified, the author has used a pseudonym.

We also employ two registered nurses, a combination lab and x-ray technician, a general aide, a bookkeeper and a receptionist. We do not have a business manager, but our books are audited by an accounting firm.

After the trial period, I started off as a full partner. It cost me $15,000 to buy in, and I had the choice of paying the full amount or taking it out of my earnings over a period of years.

I decided to pay the full amount.

My main reason was that I wanted an equal voice from the start, a say about policy matters and the day-to-day workings of our group.

I realize that $15,000 looks like an impossible amount for most any resident to raise. I did it by tapping savings, taking a fat bank loan, and borrowing the rest from relatives. In another year, my fourth, I will have paid off these debts.

Incidentally, the price was figured as one-quarter of the group's assets. They consisted of the medical building and its land, all the equipment, all accounts receivable. (Today my quarter share is worth about $20,000, which strikes me as a pretty good investment.)

We each draw $1000 a month in salary. Then at the end of the year we divide the profits—the excess of group income over group expenses. This year I expect my total net income to hit $18,000, before taxes.

Profits are divided according to the contribution to the total practice that the doctor has made during the year. This is based on billings, not collections. (If we did not do it this way, and simply divided the profits into four equal shares, both the AMA and the American College of Surgeons would consider it fee splitting.)

My contribution to the practice has grown each year, and in a few years I expect to be bringing in about 40 percent of the total fees. I have this potential as I do all of the major surgery.

Would I be making more money as a solo practitioner with a comparable practice? Yes. The reason for this is that the overhead for our group comes to about 45 percent of our income. The solo practitioner's setup is usually less elaborate, overhead quite a bit lower.

Contract

The financial arrangements are all spelled out in our contract. Before I signed I consulted a lawyer, a precaution that I think is necessary. As a result, I did not

sign a contract that simply bound *me* to the group, but a contract that was binding for all of us.

Let me explain. In view of the fact that my youngest colleague was in his early fifties and the other two close to sixty, I made sure a fitness clause was inserted in the contract. This states the financial and practical arrangements which automatically come into force in the event that any partner becomes permanently incapacitated, unable to hold up his share of the practice.

My lawyer and I also saw to it that I got another kind of protection. This was in regard to any one of us quitting and setting up his own practice. At first my partners asked me to sign a covenant that I would not, during the next five years, set up my own practice within a 20-mile area. But what about the opposite situation? What guarantee had I that any one of my colleagues, each of whom had a good following, would not set up his own practice? This was unlikely, but still a possibility.

When I made my feelings clear, my partners saw the point and agreed to a covenant restricting all of us. Such covenants, by the way, have stood up in many court tests.

As a full partner, I had a suggestion to make at the very start. It was about the way house calls were handled. Before I joined, each doctor took care of his own. This seemed to me to be inefficient, the losing of an advantage —more free time—that is to be gained through group practice.

Easier schedule

We discussed this and came up with the schedule we still follow. Every fourth night and every fourth weekend, one of us is on call, acting as the officer of the day, you might say. (Of course if it's my patient and a serious case, I'll go out if it's my night or not—my partners operate this way, too.) But this system makes it easier on all of us, and gives us a chance to live a fairly normal life.

At first, my colleagues were afraid that their patients wouldn't like the system, but they finally agreed to try it. To be sure, a few patients did grumble, but in time even they fell in with the scheme.

Our patients now know that they can get a doctor quickly at night, a doctor who is not fatigued and out-of-sorts because of a too demanding schedule.

We each have a month's vacation, which we can take in one stretch or a week or two at a

time. But none of us is off during the summer when our practice is heaviest.

Each of us has office hours five days a week. Mine are in the afternoon so that I can operate in the morning.

Surgical practice

By now you may be wondering how this practice has worked out in regard to my specialty. The answer is, very well. Actually, about 95 percent of the medicine is handled by my colleagues. The only time I do any is on my duty nights and weekends.

I know that I have done much more surgery in the past three years than I would have as a solo practitioner in a large city. Instead of waiting months for my first referral (as happened with friends of mine), I plunged right into a busy practice and thus kept my skills sharp. Except for heart work, I do the complete range of general surgical procedures.

In the process I've built up quite a following. This is not simply because of my competence as a surgeon, but because I am on the scene, from pre-op to post-op. This means a lot to the patient. For example, there have been cases in our area handled by big-name surgeons from one of the nearby cities.

There can be no question of their skill. But, with the operation over, these surgeons head for home. The post-op responsibility falls in my lap or that of the GP on the case.

Patients have told me that they prefer to be operated on by a surgeon who stays with them from beginning to end. I do all my own post-op work as I have neither residents nor interns to help me.

Which brings up the subject of hospitals. In this respect I have been very fortunate. I do most of my surgery at a nearby nonprofit general hospital. It now has 60 beds but this will be increased next year as part of a million dollar expansion program.

Not only did they grant me major privileges at this hospital within a very short period, but two and a half years later made me chief of service—a break that not too many young surgeons get. I am also associated with two other hospitals.

Drawbacks

So far I've painted a fairly glowing picture. I must admit there are drawbacks to my particular setup, although they are factors I can live with.

The main problem is the age of my colleagues. They have

reached the point in their careers where they are not greatly interested in expansion (though we are planning to add a pediatrician next year). I would like to put up a brand-new medical building with better facilities than we have now, a building with a more "professional" look. Our present place, with its narrow halls, partitions and cramped offices, sometimes strikes me as a cluttered rabbit warren.

My colleagues' views on getting new equipment also tend to be more conservative than mine. As is spelled out in our contract, we all have to agree on any purchase over $35, and this has caused friction from time to time.

I am 36 now, the youngest man in the group by 17 years. Thus I can look forward to the day when I am the "senior" member or perhaps even sole owner, if that becomes my goal.

But when I weigh such considerations against the advantages of having colleagues in my own age bracket, I would choose the latter. Working with younger men, eager to try new things and to expand the practice, would be a more dynamic and satisfying experience.

But another factor is even more important than age, and that is the personalities of the men involved. I feel sure that in most groups that fail, a personality problem was at the bottom of it. (I know of several such cases.)

You have to be willing to make compromises and to try to see things from your colleagues' point of view. If this is difficult, or impossible, for you to do, then you don't belong in a group.

We have had our differences in our group, but have always managed to iron them out. I have always been most direct in my dealings with my partners. If I have a gripe, I tell them about it and listen to their side. This has kept differences to a minimum and cleared the air quickly. When one member begins to nurse private grievances, you're bound to have trouble.

No pressure

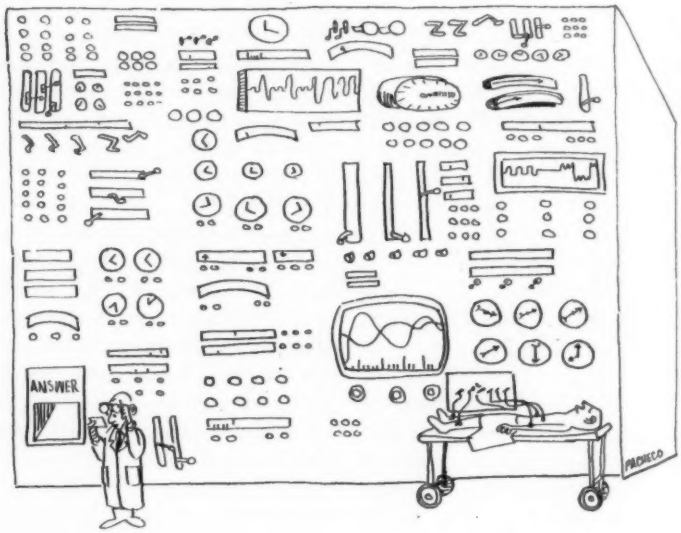
There is a final aspect to this business of group practice that must be considered. That is the social side. I've read about groups where senior members exert social pressure on the younger men, where the juniors have to operate within a closed social circle, have to join the "right" clubs, buy the "right" kind of house, car, etc.

Well, once again I have been fortunate. Social relations within our group can best be described

as casual. We attend dinners and parties at each others' homes occasionally, but that is about the extent of it. Being appreciably younger, my wife and I have a different circle of friends, which suits both us and my colleagues.

Taking everything into consideration—my professional as well as my private life—I am satisfied with the way things have worked out. And so is my wife. We have a nice home in a pleasant town, the kind of place where kids thrive and adults have time to be friendly.

And when we get the yen to take a trip or to spend the weekend in New York, all we have to do is hop in the car and go. Those are the times that I really appreciate the fact that I'm in group practice, doing the kind of work I like—and yet with the time for my wife and I to have a life of our own.



The Training of a Psychiatrist

Here are eight principles to guide the department faculty in a training program for residents in psychiatry.

Maurice Levine, M.D.

Professor and Director, Department of Psychiatry
College of Medicine, University of Cincinnati

In recent years some fascinating problems have developed in the teaching of interns and residents. Particularly is this true on a psychiatric service.

On the surface, hospital training seems simple and easy. Apparently all that is necessary is to have a group of intelligent and well-trained house officers, give them increasing responsibility in the actual handling of patients, and supervise their work through ward rounds and other well-known teaching devices.

But life is far from being so simple. Such a plan could lead to a number of serious omissions and distortions in a program of training and at times could produce a psychiatrist whose experience in some ways had been as negative as it was positive. To avoid such a misfortune, it is urgent that a department faculty be guided by some well-tested principles. In this paper, some of the guide-lines in the field of psychiatry will be discussed, with special emphasis on the ways in which the general principles may be implemented in an on-going program.

Open door

The first principle can be called "the open door policy," by which one means that it is wise to have a good part of a resident's training be on a service in which patients are not too well screened in advance, in which the service does not serve only a limited group of citizens of the com-

munity, and in which the admissions are not based on the selection of those who are suitable for a staff man's research projects or of those who are suitable for a limited kind of treatment.

Patients should be accepted if they have, or seem to have, some sort of psychiatric disorder, no matter what the disorder may be, so long as there is a bed available. The result is that during the course of a year such an unselected group of patients will provide a tremendous variety of clinical experience for the resident rather than the limited or skewed experience which is so frequent in a specialty service.

Admissions

The above principle of the open door must then be integrated with a second principle, viz., that the service should not take patients beyond its bed capacity. The open door policy often exists in hospitals which are not able to control the total number of patients, and so the great positive value of having an unselected group of admissions is more than vitiated by the fact that patients then are placed in beds in the center of the ward or in a corridor, eventuating in a patient load too large for good nursing care, and too large for thorough study and adequate treatment. Or the situation may result in an overly rapid disposition and discharge, to make way for new patients, producing a turnover so rushed that adequate study is impossible. Consequently, the open door policy must be modified by a policy of having an upper limit on the number of admissions.

The above two principles are of interest to the readers of RESIDENT PHYSICIAN from another point of view as well. These principles are examples of a basic pattern of administration, to which the attention of house officers should be called, since many current house officers will be in administrative positions in the future.

Experience

Some of us who have had to assume administrative responsibilities, even though our training was primarily in the field of medicine, have learned the hard way that some principles of administration can be evolved which stand up well under experience.

One principle is that the functions of an agency or an organization or a program should be delineated clearly.

A second is that the successful implementation of a function de-

velops best when the function has been built into the very structure of the organization. A medical house officer certainly can find this concept in keeping with his usual thinking. He knows that the function of a muscle or of a bone or of a gland is to a large degree dependent on its structure. Similarly, one can decide, as a first step, that one important function of a psychiatry residency program is to provide experience with a large and unselected group of patients so that residents will develop some know-how with the entire field rather than with a limited segment of the field.

Then, according to the basic concepts of the relation of structure and function, it is wise to build this function of the training into the very structure of the department, e.g., by having an "open door but upper limit to admissions" policy be a part of the structure of the department, part of its rules and regulations and actual practice.

Psychoanalytic

The third general principle in a psychiatry residency program is that the dominant emphasis should be placed on the psychoanalytic approach. On this point, of course, some psychiatrists would disagree, but this paper is the summary of the experience of one psychiatrist, myself, and of my evaluation of the status of the field. And so I must express my deep conviction that the overall approach stemming from the work of Freud is the core of modern psychiatry.

Please note that I am not recommending full psychoanalytic institute training as a necessary part of specialty training in psychiatry. Rather, I am recommending that psychiatry residency training should center around certain ideas which derive from psychoanalytic research and knowledge, ideas which in this context can best be called "psychodynamics and psychotherapy."

Please note further that I regard a number of other approaches in the field of psychiatry as being of great importance as well, and I shall discuss these issues later.

I am not suggesting an "all or none" approach. I insist that other approaches to the field of psychiatry be included, but my experience makes it imperative that I underline the importance of having the "psychodynamics and psychotherapy" approach be the major line of emphasis in teaching.

Based on my actual experience

with patients and with residents, I must assert my conviction that a large part of human helpfulness essentially is based on an understanding of individual dynamics, i.e., of the emotional forces at work within the individual, and on the skill with which the psychiatrist has learned to handle such problems.

A large part of medical work with human beings is dependent on an understanding of psychologic conflicts, of anxiety, guilt, shame, sexual drives, dependent wishes, competitive feelings, destructive impulses, conscience, disappointments, self-aggrandizement, etc., the material studied most effectively by the psychoanalytic approach in psychiatry.

Key

The fourth general principle arises from the fact that there is a great danger as well as a great gain involved in the emphasis in residency training on psychodynamics and psychotherapy. This is an enormously valuable area of understanding, a tremendously valuable set of tools to put into the hands of the developing psychiatrist, but it provides difficulties as well. It is an area of great fascination for a sensitive and perceptive house officer. It is seductive. There inevitably is a serious temptation to make it the be-all and end-all of psychiatry.

When a psychiatrist-in-training learns about human dynamics, he is dealing with those issues which have interested and fascinated all of the great minds of the past, all of the great novelists, historians, dramatists and poets. A study of psychodynamics means a study of sexual and of murderous impulses, of fear and of guilt, of achievement and of failure, of love and of hate. Small wonder then that a resident who is being taught to understand his patients in such terms will be tempted to think that he now has "the key to the absolute," "the real McCoy," the one thing which will interest him for the rest of his life.

The basic problem confronting the teacher and the resident in psychiatry is whether he can have the guts and the gumption to make full use of such enormously valuable material without succumbing to the temptation to find it so fascinating that he will forget everything else.

Somatic

This leads then to a statement of the fourth principle of psychiatry residency training, namely, that into the structure of the pro-

gram must be built safeguards against the temptation to think that the whole story of psychiatry is to be found in psychodynamics. For example, it is necessary to pay a great deal of attention in the planning and the carrying through of a program to the maintenance of the resident's alertness to somatic factors.

The open door policy is one of the best ways of reaching such a goal. Under this regime many patients are admitted simply because they are disturbed. Often such patients are thought to have some psychogenic illness, but the actual work-up in a specific case may demonstrate that the disturbance, although it seemed psychogenic at first glance, was not psychogenic but somatic in origin.

For example, a patient who was admitted recently with a tentative diagnosis of hysterical breathing disorder was found after admission to have silicosis with respiratory difficulty.

Another patient who was admitted with a diagnosis of hysterical vomiting was found to have a hyperparathyroidism.

We are enormously pleased by the fact that in one year recently the only diagnosis of typhoid fever made in this city was made by a psychiatry resident on a psychiatry service.

Rotation

Further, a resident's alertness to somatic factors is fostered by his rotation on the neurology service, by his joint work with residents of other departments in the psychosomatic ward, by his joint work with them on the consultation service, etc.

He will see subdural hematomas, brain tumors, pancreatic tumors and many other somatic disorders which produce psychiatric manifestations, as well as a myriad of somatic symptoms caused by anxiety and other psychologic agents in etiology.

With such a principle, of fostering an alertness to somatic factors, and with the structuring of the program so that the principle actually is implemented, one can feel safe in emphasizing the emotional problems of patients and their treatment by psychotherapy. One then can be relatively sure that residents in their future work will have an adequate sensitivity to the possibility of somatic factors in psychiatric illness, even though they recognize that psychodynamics and psychotherapy are the largest components of the field of psychiatry.

The fifth principle which can govern a residency training program in psychiatry is that it is urgent to provide an emphasis on

the interpersonal as well as on the intrapsychic.

This principle involves a somewhat different area than the fourth principle, but again the starting point is the same. The inner dynamics of the individual patient, his love and his hate, his sexual and hostile impulses, is a topic of such fascination and interest that it tends to throw into the shade those aspects of human experience which can be called interpersonal rather than intrapsychic.

To define for a moment, one can say that inner conflicts, hidden and unacceptable urges, such as the conflict between dependency and independency urges, are to be called intrapsychic. Guilt over hidden hostile and sexual impulses, leading to self-punishment and depression, is another typical intrapsychic sequence. Such inner patterns are part of the great discoveries of dynamic psychiatry of the last 50 years.

Sources

But in the fascination of such new insights, one must not forget those conflicts that arise between human beings as well as the conflicts that arise between various segments of one person. (Of course at this point we are not referring to early childhood experiences in which conflicts between human beings lead to conflicts within the personality of the child; rather we are referring to current conflicts with other human beings.) The fact is that even though human intrapsychic problems are extraordinarily important and extraordinarily dramatic and exciting, it still remains true that an individual is in constant and meaningful contact with other human beings, within the family, in his neighborhood, in his community, in his church group, etc. Interpersonal situations as well as intrapsychic may be sources of strength and may be sources of difficulty and symptom-formation.

Community

Consequently, a residency program must include the principle of providing many opportunities for the study of interpersonal relationships. With such a principle, an overemphasis on the intrapsychic cannot develop, even in a program in which the psychoanalytic influence is predominant.

And again the function must be built into the very structure of the program. For example, in Cincinnati the program is supported not only by the medical school and the university hospitals group, but also by the Com-

munity Chest. The psychiatry center is at one and the same time a department of the medical school, a service of several university hospitals, and an agency of the Community Chest (its mental hygiene clinic).

Residents in this program, therefore, function in one role, as community psychiatrists. They participate in the psychiatric diagnostic work-up of patients referred by 115 social agencies and in the on-going clinic treatment of some of the patients referred by these agencies.

As part of the collaborative work of this Community Chest clinic and the social agencies, a number of interagency conferences are held on a regular basis, in which each group contributes to the understanding of the total situation.

Emphasis

The end result is an inevitable emphasis on interpersonal problems to add to the emphasis on the intrapsychic.

In one day in the life of a resident, he may have a seminar in the morning in which the seminar leader and the group discuss the intrapsychic dynamics of one of the patients whom the resident has been following in long-term psychotherapy, followed by an afternoon interagency conference which stresses external and interpersonal forces.

In the seminar on dynamics, the resident may come to see the ways in which his patient (perhaps a bright student who is flunking) not only has a strong drive toward success but also a great fear of success based on distorted notions about the destructiveness of the competition which might be involved in his progress and his success.

In the interagency conference later, the resident will hear the case workers of his own center or the case workers of other agencies discuss the pressures on another patient by the patient's wife or by his employer, or the problems of his adjustment to a new social environment after he moved from an isolated rural area to a job in a large factory and to home life in a crowded urban area.

Social forces

In this instance the fact that the resident participates in seminars on psychodynamics and psychotherapy and concurrently participates in interagency conferences and in collaborative treatment with other agencies, provides a program structure which makes it certain that his training

will satisfy a basic principle, that he develop an understanding of interpersonal dynamics as well as of intrapsychic dynamics.

In such training, one of the central concepts in psychiatry, the role of sociologic factors, can not remain merely an academic notion. The resident will have seen social forces at work in actual patients.

Also for him there will be little sense in the recurrent controversy in the psychiatric literature as to whether the fundamental psychologic forces are interpersonal or intrapsychic, since he will have seen both in action and in interplay, and will know that in some cases the intrapsychic forces predominate, and in other cases, less frequent but still important, the interpersonal forces predominate.

Medical world

The sixth principle basic to the structure and function of a psychiatry residency training program is that the resident should remain a part of the medical world. It is easy for psychiatrists to divorce themselves from other physicians and to follow their own interests in the direction of working with their own patients. But certainly one of the lessons of the last half-century has been that there is a tremendous value, both ways, in a close relationship between psychiatry and the other medical disciplines.

In a residency program in which psychiatry and the other medical disciplines have many points of contact, psychosomatic problems and somatopsychic problems become a real part of the training experience of the resident in psychiatry.

He learns that he can be helpful in the handling of delirium on the medical service. He learns via actual experience, not merely by reading, that anxiety and some of its effects modify seriously the outcome of surgical procedures. He learns that many patients who have severe neurotic problems also have basic somatic difficulties, and that in some instances, only a joint approach with other physicians can do the job.

And he can learn in the give and take of doing consultations on other services, and of residents of other services doing consultations on psychiatry, that many primary medical disorders may produce psychiatric manifestations difficult to differentiate from those which might be produced by intrapsychic and interpersonal conflicts and pressures.

Another principle of a psychiatry program, the seventh of this

series, is that the resident must work hard, and work long hours, but at the same time must have ample opportunity to play, to be with his family, to have an adequate social life.

There is a rumor these days that residents want bankers' hours. I doubt very much if this is true in more than a rare individual.

Year after year I find that residents in this group of hospitals and clinics work long hours, willingly and energetically.

Chance to think

But an urgent element in the maturation of the resident is that he should not work more than one night out of four or five. He needs to have a chance to think, to grow, to be with other people, to develop his leisure and his hobbies.

Many of our residents are married and it is not good for a resident to be so tied down with his residency training that he has too little time to be with his wife or with his children.

In addition, such a program of hard work during the day plus free time most evenings, actually facilitates the learning process.

There is a limit to the productiveness of continuous intensive work.

This is true particularly in the field of psychiatry, in which there are many new concepts which the resident must understand intellectually, but even more important, which he must integrate as a part of his spontaneous feeling and behavior.

Grow

Psychiatry demands that one grow up, that one assume some great responsibilities, that one give up some of the residual thinking of one's childhood and adolescence, that one change one's incorrect notions about sex, about competition, about fear and anxiety, about omnipotence and magic.

Further, a career as a psychiatrist requires that one renounce the right to express one's anger at patients, that one grow beyond one's fear of patients who are dominating, that one have time to develop some effective changes in one's outlook, one's adjustment, and one's own inner dynamics.

Respect

One of the most important of all of the principles of a psychiatry training program, the eighth of this listing, has to do with the development of a self-respecting psychotherapy. Some

25 to 50 years ago, when it became clear that the development of psychoanalysis provided the first really worthwhile and acceptable approach in psychotherapy, it seemed necessary to recommend that all serious students of psychiatry have training in an accredited institute for psychoanalysis.

Such training in psychoanalysis *per se* at that time was the most important aspect of the total training in psychiatry after the internship.

But during the last 25 years it has been shown that this is not the only solution. It now is possible to have a residency program in psychiatry in which enough psychoanalytic facts and principles of understanding, and enough psychoanalytically oriented psychotherapy, can be learned, so that the end product is a psychiatrist who can do psychotherapy about which he can have a very real self-respect.

During his three years of residency training he has learned enough of psychodynamics and of psychotherapy so that he can do an adequate job with a large variety of patients, even though he has not had full training in a psychoanalytic institute.

At the same time he has learned enough of general clinical diagnosis, of ward management, of group psychotherapy, of somatic methods of therapy and other aspects of the field of psychiatry, so that he can function as a general psychiatrist in a variety of ways, in addition to his skills in psychotherapy.

He then, of course, can go further with specific training in an institute of psychoanalysis if he becomes convinced that long-term, individual psychotherapy is the area which interests him the most and for which he would like to have more extensive training. After training in a psychoanalytic institute, he then can deal with patients at an even deeper level of understanding and do a more thorough reconstructive psychotherapy, for which it seems wise to reserve the term "psychoanalysis." And if he decides not to have analytic institute training, he can continue to do a self-respecting psychotherapy and develop professionally in other ways.

Logical plan

Such a plan, in which a resident who wants analytic institute training in addition to psychiatric residency training (and is accepted) will postpone his institute training until the latter part of the residency training, or until the

residency is complete, seems to many of us the most logical and the most effective arrangement. It is a good plan, however, only if the residency training prepares him to do a good psychotherapy. Only then can he feel comfortable in his work as a psychotherapist.

With such a plan, his training in general psychiatry can receive his undivided attention for two or three or four years. Further, he can have his psychoanalytic institute training, if he decides to have it, at a time when he can afford it more easily. By the end of his residency training he can find a good job or begin a good practice and be able to have analytic institute training when his income is such that concurrently he can pay for his institute training and can meet the needs of a growing family.

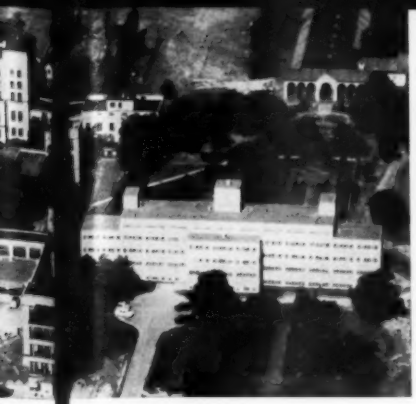
The above, then, comprises some of the most important principles of a training program in psychiatry. There are many other principles which have become clear and could be discussed in a paper such as this, but a long paper becomes too heavy. A discussion of other principles will be presented in next month's RESIDENT PHYSICIAN.

EDWARD J. MEYER

A major teaching facility of the University of Buffalo School of Medicine, this hospital provides board approved training for 110 house staff officers in 14 specialties

The Edward J. Meyer Memorial Hospital, a 1,008 bed county hospital set in a 65 acre park, began as a two story pest house for smallpox over a half century ago.

Though the scourge of smallpox was soon to vanish, tuberculosis yearly claimed the lives of many citizens. In 1912 it was decided to erect a modern hospital building for tuberculosis and six years later the new Buffalo City Hospital at 462 Grider Street opened its doors. Though originally intended for tuberculosis patients, economy and efficiency required that its use be expanded to include the treatment



one of
a series
on
leading
resident-
intern
centers

ER MEMORIAL HOSPITAL

of every type of human illness.

Originally three buildings of four floors each, three buildings were added in 1922, and in the following year a new structure for communicable disease was completed. The next year a Crippled Children's School was opened; and in 1951 a modern new psychiatric wing was constructed.

The hospital was renamed the Edward J. Meyer Memorial Hospital in 1939 in memory of the doctor who headed its board of managers from its creation until his death. On July 1, 1946 the institution passed from city to county control.

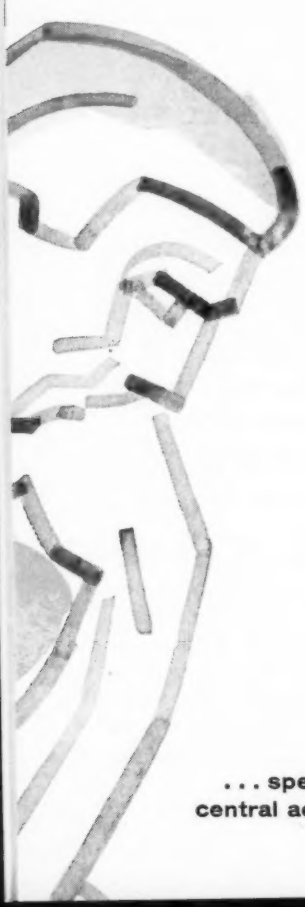
During these years, Western New York's largest hospital has been a pacesetter in resident training, a university-affiliated nursing program, tumor clinic, cancer detection center, and schools of x-ray technology, dietetics, medical technology and the first school and treatment center in the country for handicapped children.

The Edward J. Meyer Memorial Hospital is a county institution dedicated to the care of the indigent sick. All patients are staff cases. As such, the responsibility for their care rests with the house staff, guided by the attending physicians with ultimate

mind and muscle

in skeletal-muscle disabilities . . .

for whole-patient response in spasm, rig



Of all muscle relaxants in current use, only meprobamate is supported by hundreds of clinical studies that demonstrate relaxing action on both brain and skeletal musculature. This is why EQUANIL stands as the obvious choice of many physicians concerned with whole-patient response. EQUANIL reduces muscular spasm and tension, aids in the restoration of mobility, speeds rehabilitation, lessens the emotional overlay.[1-6] Its margin of safety is shared by few agents in medical practice.

1. Mitchell, E.H.: M. Ann. District of Columbia *27*:190 (April) 1958. 2. Cooper, C.D., and Epstein, J.H.: Am. J. M. Sc. *235*:448 (April) 1958. 3. Vazuka, F.A.: Neurology *8*:446 (June) 1958. 4. Cobey, M.C.: Am. Surgeon *24*:350 (April)1958. 5, 6. Wein, A.B.: M. Ann. District of Columbia *27*:346 (July) 1958; Clin. Med. *6*:44 (Jan.) 1959.

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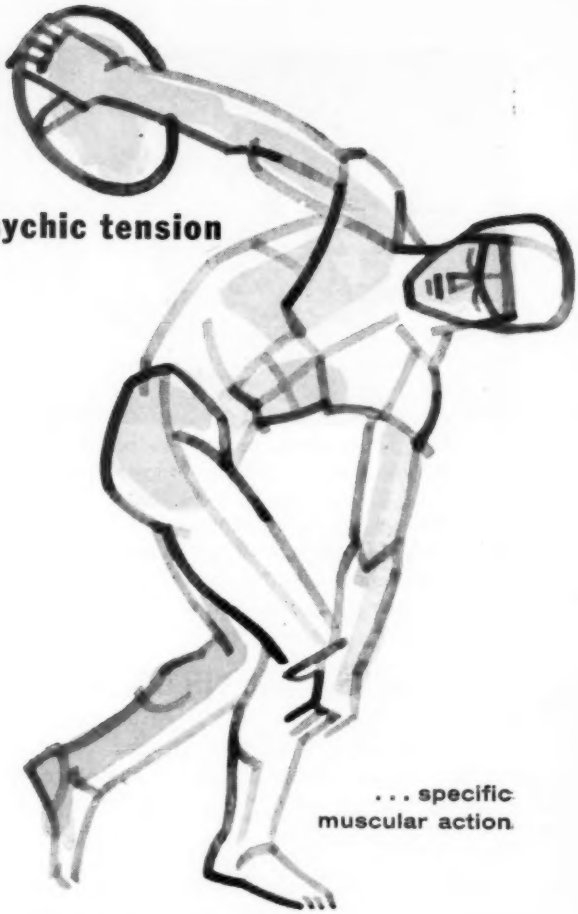
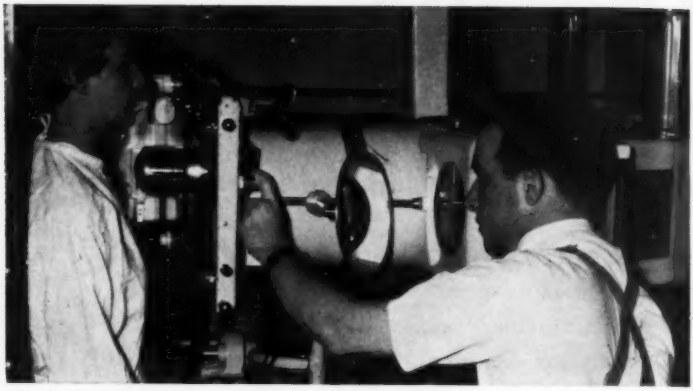
rigidity, psychic tension



. . . specific muscular action

Partial indications—spasm or tension secondary to:

sprains, strains, contractures
fibrositis, myositis
low-back syndrome
whiplash injury
frozen shoulder
cervical-rib syndrome
herniated intervertebral disk
wryneck
rheumatoid arthritis
rheumatoid or traumatic spondylitis
certain neuromuscular disorders



Above, a radiology resident makes an adjustment preparatory to fluoroscoping patient. Instrument is equipped with an image amplifier.

jurisdiction vested in the department heads. In general, department heads render full time service to the hospital and hold professorial rank at the University of Buffalo Medical School.

Each of the departments in its house staff teaching aims at the development of a well-rounded, top flight physician who will excel in his field.

House staff

The house staff of the Edward J. Meyer Memorial Hospital is composed of 110 interns, residents and fellows. This medical personnel is necessary in order to adequately staff the largest of the major teaching hospitals of the University of Buffalo School of Medicine. In its capacity as a major teaching hospital it is responsible for the instruction of half the junior and senior classes of the medical school. The teaching role of each house staff member is an important one, enhancing his educational experience. And it is in this critical atmosphere that the training of interns and residents is accomplished.

The Edward J. Meyer Memorial Hospital offers 24 rotating internships. Interns are appointed according to the procedure outlined by the National Intern Matching Plan.

The year is arranged so that each intern spends four months on the general medical service,

four months on the surgical service of which one month is an elective, and one month each on OB-GYN, pediatrics, psychiatry and the chest disease ward. This is not intended to be a rigid division and has been altered within reasonable limits to suit individual preferences and requirements.

The intern is usually assigned between 20 and 30 patients when on the wards, and in addition spends time in the out patient department and in surgical first-aid in the admission department.

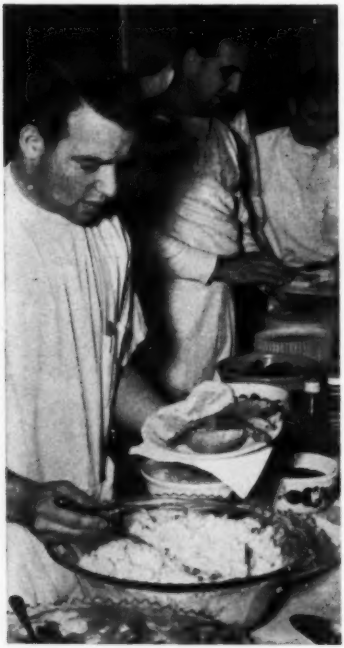
Interns receive a salary of $2775 yearly. In addition they are provided with meals, laundry for uniforms and quarters when on duty. Interns are allowed one week's vacation per year.

There are 14 programs approved for residency training at the Edward J. Meyer Memorial Hospital. In some instances the length of the program exceeds the normal requirements of the certifying boards. Residencies are columnar, not pyramidal, and residents appointed to the house staff have the opportunity to complete all of their training at the hospital. Detailed information about specific residencies can be had by writing to the chief of service.

It has been pointed out that patients are staff cases and provide all candidates for a house staff education with an unlimited clinical material. The experience is all the more valuable because responsibility for patient care devolves on the resident and his intern. House staff members are encouraged to exercise independent judgment commensurate with their experience. The attending staff serves a consultative role. Bedside teaching

I^{131} thyroid scanning equipment is employed by two radiology residents.

Surgical bedside teaching rounds conducted by an attending surgeon with medical students and charge nurse on floor. Below, residents and interns make the most of a house staff party held on the Meyer Memorial grounds.



rounds are, of course, a daily occurrence on each of the services. In addition there are innumerable teaching conferences as well as periodic appearances of prominent guest lectures in which the house staff either takes an active part or at which it is encouraged to be present. Nothing is spared to make available the most recent diagnostic and therapeutic tools.

Whether a resident be engaged in ward work, surgical research in the animal laboratories, radioisotope investigation, cardiac catheterization, pediatric research or in the subspecialties of medicine and surgery, his entire training program is so designed that every facet contributes to the attainment of a broad, though specialized medical knowledge.

The outpatient department is an important element at Meyer Memorial. Forty specialty clinics meet 100 times weekly to care

for over 100,000 patient visits annually. As is true with inpatients the care of this large outpatient population is the responsibility of the house staff. Senior staff members are always available for consultation. An especially important section is the very busy surgical first-aid division under the supervision of the surgical resident.

The clinics enable the staff to follow a patient and his disease after discharge. In the medical clinics for example, a resident will follow patients for his entire three or four year period of training. Nothing is permitted to interfere with this continuity of follow-up.

Meyer Memorial Hospital supports its own medical library.

The library owns over 7,000 volumes and receives 276 current medical journals. In addition, there is a lending service with the University of Buffalo so that material not at the hospital is readily available.

A branch of the Buffalo Public Library is an integral part of the hospital library.

Salaries

Resident salaries, psychiatric residencies excepted, begin at $2975 yearly. Each year's service brings an increment of $200 so that a fourth year resident receives $3575. Chief residents

EDWARD J. MEYER MEMORIAL HOSPITAL
APPROVED RESIDENCIES

SERVICE	CHIEF	TOTAL RESIDENCIES	PROGRAM YEARS
Anesthesiology	Benton D. King	5	2
Dermatology	Earl D. Osborne	3	3
Internal Medicine	David K. Miller	21	3
Neurology	Bernard H. Smith	2	2
Obstetrics & Gynecology	Edward G. Winkler	5	4
Ophthalmology	W. Yerby Jones	4	2
Orthopedics	James P. Cole	2	3
Pathologic Anatomy	Samuel Sanes	3	2
Pediatrics	Thomas S. Bumbalo	3	2
Psychiatry	S. Mouchly Small	9	3
Radiology	Edward G. Eschner	6	3
Surgery	John D. Stewart	15	5
Thoracic Surgery	John D. Stewart ..... (4 years general surgery prerequisite)	2	2
Urology	Ernest L. Brodie	4	3

Psychiatry resident receives certificate from hospital superintendent at annual graduation dinner for interns and residents.

earn $3975. Psychiatric resident salaries begin at $3875 with yearly increments of $700 bringing the second and third year salary to $4575 and $5275 respectively.

Recreation

Spacious, well-kept grounds with facilities for tennis, football and baseball are available.

In-hospital recreational activities include ping-pong and television.

Housing

The hospital provides quarters for its house staff only when they are on duty at night. However, housing is readily available for both single and married physicians in the immediate and outlying areas. Though the hospital is a county institution serving a predominantly indigent population, it is located in a very pleasant residential area. Contiguous with hospital property are attractive, new, municipal housing apartments which rent for approximately $40-$50 monthly, utilities included, and a well supervised public swimming pool.

Job opportunities for interested wives of house staff members are abundant and varied. More detailed information may be had by writing the Secretary of the Committee on House Staff Education, Edward J. Meyer Memorial Hospital, 462 Grider Street, Buffalo, New York.

L. E. Hummel, M.D.

Guest Editorial

The *TEACHING* Hospital

In the broad meaning, all hospitals are "teaching" hospitals. Professional people can hardly be a part of the hospital environment without imparting and receiving educational values. There is however today a vast difference between the *teaching* hospital and the non-*teaching* hospital. This difference, when the comparison is made, is very evident to both those inside and outside of the institution.

The happy state of self-evident recognition is not a product of statistics or of the conventional questionnaire, for though the facts and figures might well support the institution as a *teaching* hospital, the spirit of excellence, the spirit of learning just as much as possible from every endeavor, and the spirit of questioning with intelligent appraisal every thought and act, with the intent to discover the new and improve the old, it is this philosophy and substance that make a *teaching* hospital.

For this guiding lucifer we can well trade the statistical hours spent in clinics, operating rooms, ward rounds, volumes in the medical library, etc., to think in terms of the fundamental and essential concepts of

L. E. HUMMEL,
Superintendent,
Edward J. Meyer
Memorial Hospital

a *teaching* hospital and less about the raiment, be it inner or outer cloak, that such an institution wears.

In the drive to measure accurately all things, to reduce all to an exact science, the statistical rule is applied. This application of statistics and its accompanying recommendation for uniformity all too often reduce the superb to the excellent along with elevating the poor to the good. There is, however, danger and certain undesirability in bringing about uniformity at the expense of striving for the better, instead of the superb.

A *teaching* hospital must be a community of constant self-appraisal and ubiquitous healthy discontent with its attainments. For if it does not suffer from this latter chronic hypochondria it is in danger of a more serious malady, creeping paralysis. Does this mean that a *teaching* hospital is one in a perpetual state of ill health? Not at all, any more than the hypochondriacal patient is in a state of ill health. If, however, the hypochondria is accompanied by a state of do-nothing-about-it or a feeling of comfortable acceptance, then the hypochondria has become a condition of ill health. This feeling of benevolent unrest in the ideal *teaching* hospital will be diffused throughout and be a part of boards of managers, administrative, professional, and non-professional staff.

It is important to recognize that a teaching hospital is not necessarily formally or informally associated with a university or medical or other professional school. Such association, however, does enhance, through its educational facilities and atmosphere of learning and

investigation, the endeavors and attainments of the *teaching* hospital.

It is important to know the *teaching* hospital as well as the teaching hospital. The latter is like the child of adoption that proves to have little in common with its parents, whereas the former is a child of inquisitiveness with indulgent and wise parents. To be sure, not everyone is in total agreement as to the degree of indulgence that will develop the best child but there is, happily, an increasing appreciation that a superior child may be retarded by conformity, and that this is within our power to avoid.

The *teaching* hospital's role in American medicine is a fledgling in the history of hospitals, and attempts at uniformity may singe the birthright of a prodigy. A *teaching* hospital that has not reached maturity is not a juvenile delinquent. A hospital accreditation should be a welcome educational experience, not a punitive action.

The *teaching* hospital today, in addition to growing up, and striving toward maturity, has been and continues to be, at an increasing pace, more and more like an educational institution. This similarity in educational aims must be accomplished within the encirclement of service to patient and community. The point in medical care has arrived in a *teaching* hospital where a technique, a procedure, or a piece of equipment may be in one instance a research project and the next day a lifesaving modality. Often, the same doctor, the same instrument, and the same team may be functioning in this dual capacity. This is an essential feature of a *teaching* hospital or otherwise it is not teaching. This is only one of the very important features of such an institution, which must be recognized by trustees, administrator, patient, staff, public, and ac-

crediting agency if the *teaching* hospital is to grow in stature, service, and educational value.

The *teaching* hospital today is very much a pioneer in an area where even the frontiers have not as yet been mapped. The pioneer spirit of wanderlust, of daring adventure, of danger fought and explored with intelligent direction, not uniformity, must be the means by which the *teaching* hospital arrives at maturity in its particular environment. It is important at this time that it not try to conform but by every thought and act be an innovator of the superb.

Come back! I said, "closing" not "closed!"

Clinico–Pathological Conference

Edward J. Meyer Memorial Hospital

R. G., a colored male, was born 6/6/57 at the Edward J. Meyer Memorial Hospital, the product of a 35-week gestation. There is a questionable history that the gestation was complicated by tuberculosis.

There was no analgesia. Delivery was effected by a low forcepts from an ROA position, under spinal anesthesia. The baby breathed spontaneously; cry and color were good.

Examination at birth revealed a weight of 4 lb. 12 oz., length of 17 inches and chest girth of 11 inches. Head measurements: circumference, 12 cm; BP, 8.5 cm; BT, 7.5 cm; SOB, 9 cm; OF, 10.5 cm. Fontanels were soft. Breath sounds were bilaterally heard. Heart: normal sinus rhythm. No abdominal masses. Cord Wasserman was taken. The external genitalia and extremities were normal. The anus was patent.

Jaundice was noted on the third day of life. Weight on the fourth day, 4 lb. 5 oz. The baby was taking feeding well. He then developed some emesis and regurgitation after every feeding. The chest showed impaired percussion at the right upper lobe posteriorly, together with roughened breath sounds. At first the formula was withheld and the child treated by H-clyses; later, with phenobarbital and atropine. With the latter therapy, the baby started to retain feedings and gained weight. The baby was discharged on the 25th day of life

having reached its birth weight, 4 lb. 12 oz. The mother was cleared of the questionable tuberculosis history.

Laboratory

Urinalysis: trace of albumin, rare granular cast; rare WBC. Cord Wassermann, negative. Hemoglobin, 19.6 gm; stools moderately positive for occult blood. Stool culture showed heavy growth of E. coli, an enterococcus; Staph. albus. non-hemolytic coagulase negative.

The child was readmitted on 8/7/57, 2 months of age, having been followed in the well baby clinic. In this period, the phenobarbital and atropine therapy had been continued. The child was readmitted for study of jaundice diagnosed by laboratory work done in the outpatient department, 7/30/57: Bilirubin 10 mg%; hemoglobin, 11.3 gm.

At readmission, the mother stated the child had had dark urine and white stools since being home.

Examination revealed an afebrile, well developed, well nourished but small proportioned Negro male in a good state of hydration. There was moderate scleral icterus, slight rhinorrhea and icterus of oral mucosa. Examination of the chest and heart revealed no abnormalities. There was a small umbilical defect. The liver was palpable 3 f.b. below the right costal margin in the midclavicular line.

After admission, a naso-pharangitis developed. Bilateral cranial tabes was observed. For 10 days, clay colored stools were noted. On the 11th day, a soft, light yellow stool was found in the diaper. The child continued to lose weight, weighing 8 lb. 8 oz. on 8/11/57, 7 lb. 11 oz. on 8/16/57, and 6 lb. 9.5 oz. on 8/20/57. Liver enlargement and jaundice were persistent. (Liver function studies, gastrointestinal series, gall bladder series were performed in addition to other laboratory tests.)

Laparotomy

Following surgical consultation, an exploratory abdominal laparotomy under general anesthesia was performed through a right subcostal incision on 9/25/57. Prior to surgery, therapy included formula consisting of 7 oz. of evaporated milk, 14 oz. of water and 2 oz. of Karo. Poly vitamins were given in addition to Vitamin K. After 2 weeks of hospitalization, Pablum and orange juice were added to the diet. Nose drops and Achromycin were given for rhino-pharyngitis.

Laboratory work. Urine: traces of bile, increase in urobilinogen, slight albuminuria. Negative for megalocytic inclusions. Stools negative for urobilinogen and bile. Trypsin, 8.

Hematology. Distinct anemia with hemoglobin dropping from 12.8 gm on admission to 8.2 gm a week later; the hemoglobin varying between 8.8 and 9.4 gm preoperatively. There was leukocytosis, up to 28,000.

Differential count. 4-6 eosinophils; predominance of lymphocytes with about 25% of the cells being bands and polys. Reticulocyte count varied from 6.4%-4.8%. Bleeding time varied 2½-4 min.; clotting time 2½-3 min. Sickle cell preparation, negative. Morphologic interpretation of blood smear, moderate to marked hypochromia anisocytosis and poikilocytosis together with slight polychromasia.

Blood chemistry. Bilirubinemia varying between 13.9 on admission and 7.8 preoperatively. Preoperatively, prothrombin time 12.5 sec. with control of 11 sec. Total protein 5.7, albumin 4.1, globulin 1.6. SGPT on admission 87 units; preoperatively, 610 units. Duodenal contents reported negative before and after $MgSO_4$.

Serology. Blood type O+; Coombs test O. Mother's blood type A+. Father's blood type unknown.

Radiology

DR. DONALD W. S. STIFF, *Assistant Professor in Radiology, University of Buffalo, School of Medicine; Associate Director of Radiology, Edward J. Meyer Memorial Hospital:*

No x-rays were taken at the time of birth. Radiographic examination of the chest at time of readmission and subsequently, revealed linear shadows extending upward and outward from the hilus, considered characteristic for linear atelectasis. With the history such as this, we have to consider pancreatic fibrosis and other processes that involve the pancreas which may have characteristic changes in the lung. However, no evidence of that is seen. Upper GI tract studies reveal a bit of delay at the pylorus. The small intestine is normal. The gall bladder studies were done, but are valueless because of jaundice. Scout film of the abdomen was negative.

DR. ROBERT J. EHRENREICH, *Instructor in Pediatrics, University of Buffalo, School of Medicine; Assistant in Pediatrics, Edward J. Meyer Memorial Hospital:*

We are dealing here with a

Negro male born prematurely with a birth weight of 4 lb. 12 oz. The delivery and prenatal period were not remarkable. This baby was mentioned to be jaundiced somewhere around the third and fourth day. The physical examination at that time is essentially negative except for some questionable rales in the right upper lung and diminished breath sounds following regurgitation of formula. The infant was taken off formula for several days and treated with clyses and some type of sedation and antispasmotic, with improvement. He was discharged on the 25th day, weighing 4 lb. 12 oz. which is a little long to regain a birth weight even for a premature infant. After discharge the patient was and is followed in the outpatient department.

The laboratory tests during this neonatal period show the cord Wassermann to be negative and there is no anemia. The stools show some occult blood which I don't think is too important. The stool culture is essentially negative, mostly E. coli.

While being followed in the outpatient department, the mother gives a history for the baby of persistent acholic stools and dark urine.

The baby is readmitted at 2 months of age with the history of apparently persistent jaundice. Physical examination at this time shows a slight upper respiratory infection and obvious clinical jaundice, a small umbilical hernia and the liver palpable 3 f.b. below the right costal margin. There is no mention of an enlarged spleen. At this point we can stop for a moment and contemplate what is happening to this infant.

First of all, this baby is clinically jaundiced with a history of persistent jaundice for 2 months. Secondly, this baby has regurgitation starting when he was a few days old and apparently continuing throughout the 2 months, although the baby weighs 8 lb., which is a good weight gain. The baby obviously wasn't losing weight despite some regurgitation. So, we are left with the differential diagnosis of jaundice in a newborn premature infant.

The things that come to mind and to be ruled out are numerous. Is this some type of abnormal physiological jaundice which has persisted, and if so, is this associated with some other type of anomaly? I'm thinking particularly of myxedema in which you get continuation of physiologic jaundice in a newborn. However, there are clinically no signs of

myxedema here. I think it extremely unusual to have persistent physiologic jaundice lasting 2 months.

Blood

Is this an Rh or some other type of blood group incompatibility? With a hemoglobin of 19.6 grams, the jaundice beginning on the 3rd day, and no subsequent anemia, I think this can be ruled out. Also, the mother's blood, I believe was Rh+.

Now, is this an ABO incompatibility? ABO incompatability is fairly frequent. I believe it is more frequent than Rh sensitivity. It is seen more commonly in Negro infants and is often seen in the first born. There is no mention whether this is a first born or not. However, the symptoms of jaundice are usually apparent within the first few hours, although it is usually much milder form of jaundice than with Rh. The serum bilirubin levels are usually lower as compared with Rh disease and there is generally not a marked anemia. Usually, the mother is a type O and the infant is a type A or B, with the mother developing iso-antibodies against the A or B. In this case, the mother's blood type was A and the infant a type O.

Does this baby have congenital syphilis? This is also a cause of jaundice in the newborn. The Wassermann was reported as negative and this baby had none of the signs of congenital syphilis.

Sepsis is a common cause of jaundice in the nursery. However, the negative cultures and the slowly chronic course of the disease, I am sure would tend to rule out sepsis. There was no history of a febrile illness here. Also, sepsis, particularly B. coli is a common cause of acute jaundice early in life; it is not a common cause of chronic jaundice.

Anemia

Does this baby have some type of hemolytic anemia? Spherocytosis is rare, at least the jaundice part of this disease in the newborn is. I doubt seriously whether this baby has any type of hemolytic anemia. The baby's primary problem was jaundice for the first 2 months, without any anemia. Sickle cell anemia also would be another cause; however, the history does not suggest this. There was no anemia in the first two months. The sickle cell preparation taken once was negative. I suppose one report is not conclusive if you're concerned about it, but this does not present the usual picture of sickle cell anemia.

Cytomegalic inclusion disease will produce a picture of hepatomegaly, splenomegaly and jaundice in a newborn. It is presumed to be a virus-like disease although the disease has never been transmitted artificially to someone else. The infant is usually much sicker and it is often a fatal disease. Also, if you look hard enough, you will characteristically find inclusion bodies in the urine. This apparently was done and a negative report was made.

Toxoplasmosis of the congenital type is another cause of jaundice. This may start within the first few days of life and usually begins with the picture of jaundice, hepatomegaly, splenomegaly and anemia. They may have a maculopapular rash, run a febrile course, develop hydrocephalus and convulsions and have delayed growth. They almost always have choroiretinitis. They have cerebral calcifications and develop into severe neurologically damaged infants. There is no history to suggest this in this infant. In fact, there is no mention of the eyegrounds.

Galactosemia

Does this baby have galactosemia? Galactosemia, as you know, is a disturbance of galactose metabolism. Normally, lactose is broken down into glucose and galactose, with galactose being converted into glucose in the liver. In this disease, there is a disturbance of the enzyme action preventing the galactose from being converted into glucose in the liver. The clinical picture produced by the elevated blood galactose is that of vomiting, poor weight gain, enlarged liver and spleen and eventually jaundice. Usually, they develop cataracts about the time they show evidence of severe liver disease. Again, there is no evidence that this baby has cataracts. There was no mention of blood glucose levels or of glucose in the urine.

I think in the case of jaundice in the newborn where you are undecided as to whether this was surgical or medical, blood sugars should be done, and if elevated, tests done to differentiate between glucose and galactose.

The treatment of galactosemia would be to take the infant off milk (containing lactose) and substitute a soybean milk which does not contain lactose. If done early, the clinical symptoms would disappear.

Finally, we are left with the problem as to whether this baby had some type of hepatitis, versus some form of obstructive biliary

disease. If we go back to the history again, we see that this baby on readmission had numerous notes regarding clay colored stools and had a bilirubin which was persistently elevated, although the bilirubin was higher on admission than preoperatively. This baby developed an upper respiratory infection, treated symptomatically plus antibiotics, and apparently something happened which did not happen before. This baby suddenly began to lose weight. In fact, it lost 2 lb. almost within 9 days, which is quite unusual. Various tests were done. The only thing I can think of which would make a baby lose 2 lb. in 9 days is either persistent vomiting or diarrhea, or an overwhelming infection.

From the laboratory work, we find that this baby had a drop in hemoglobin from 12.5 to 8 grams, although I do not know the interval between determinations. He also developed a leukocytosis up to 28,000 with a lymphocytosis and a slightly elevated eosinophilia. Again, I do not know whether the count correlates with the infection. So, I would have to infer that this baby had some type of infectious disease. I would be very suspicious perhaps that this baby developed pertussis, because pertussis can give a count of 28,000 and produce a lymphocytosis. It could also account for vomiting, poor feeding and resultant weight loss. The other possibilities could be pneumonitis, pneumonia or some type of aspiration pneumonia.

It is possible that this baby had some type of hemolytic crisis. There is a drop in hemoglobin, a reticulocytosis, and signs of regeneration in the blood smear.

Bilirubin

There is an interval of more than a month between this admission and surgery. So, I would have to infer that one of two things happened. Either this baby was being watched and being prepared for eventual surgery, or else this baby was ill and couldn't be operated on. The bilirubins were persistently elevated, however, there was no rise in these levels during a 5-6 week period. It was actually lower before surgery, than on admission.

You are forced into waiting 1-2 months to make sure that this isn't simply an over exaggeration of physiologic jaundice. Serial bilirubins, repeat hemoglobins and examination of stools and urines for urobilinogen and bilirubin and liver function studies must be done during this interval. In this baby after 2 months ob-

servation, one finds acholic stools, dark urine and a persistently elevated but not rising bilirubin. If the bilirubin level shows a steady rise, over this period, I think you can fairly safely say that this baby has some type of obstructive jaundice and you are forced into exploring this infant. If on the other hand, after 2 months, the bilirubin levels begin to lower, I think you can hold off and wait.

Now, in this particular case, the bilirubins did not rise appreciably, plus the fact that there is a note on the chart of a soft yellow stool on the 18th to further confuse us. Also, the increase in urobilinogen in the urine is somewhat against obstructive jaundice. The SGPT on admission was elevated and this becomes greatly elevated. The transaminase can be used as a liver function test, and I believe that if I can interpret this as such, it would mean hepatocellular damage. Usually, it is not elevated in obstructive jaundice.

Intermittent

The only other thing that concerns me is whether this infant had some type of obstruction other than congenital? Has this infant a tumor or a cyst which has produced perhaps an intermittent type of jaundice with backing up of bile, causing liver disease? There is no way I can think of to rule this out other than by surgical exploration.

If I were to make a definitive diagnosis in order of frequency and occurrence, I would have to say that this baby probably had a neonatal hepatitis. By neonatal, I mean that the baby probably developed this in utero from the mother who is either an active or silent carrier of hepatitis. There is no history here that the mother was ill or had hepatitis or that she had another infant before. Infectious hepatitis is rare in infants because of the long incubation period. Mothers with hepatitis do not transmit the disease to their offspring in contrast to other diseases whereby the virus and the virus of homologous serum jaundice which has been transmitted from the mother, and from the infant to another person. The other possibility would be some type of obstructive jaundice in the biliary tree, probably extra-hepatic, with the possibility that there was some type of tumor or cyst causing an intermittent obstruction. We do not know whether the baby continued to do well.

DR. EHRENREICH: Had any attempts been made through study of blood and stool to find a virus?

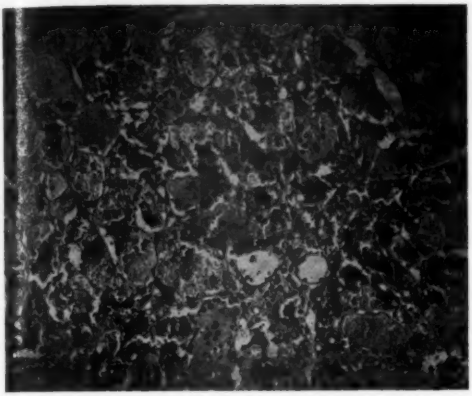


Fig. 1. Low power—photomicrograph showing hepatic parenchyma.

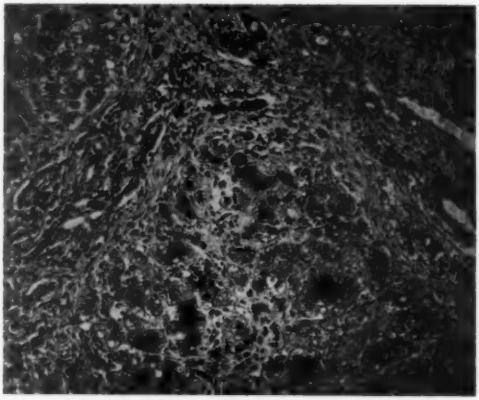


Fig. 2. Low power—photomicrograph showing periportal space.

DR. HERBERT LANSKY, *Associate in Pathology, University of Buffalo, School of Medicine; Associate Director of Pathology, Edward J. Meyer Memorial Hospital:* Yes. Studies were made and no virus isolated.

MEDICAL STUDENT: Was the child on Thorazine?

DR. LANSKY: No administration of Thorazine.

MEDICAL STUDENT: What was the diagnosis of the service?

DR. LANSKY: The diagnosis of the pediatric service was one of persistent jaundice with differential diagnosis of biliary atresia and hepatitis. The preoperative diagnosis by the surgeon was biliary atresia.

Pathology

DR. LANSKY: A small wedge of icteric liver was received for examination. Microscopic examination of the liver biopsy fragment revealed an orderly arrangement of liver lobules (Fig. 1). Edema is present as evidenced by separation of the sinusoidal lining from the cords. Within the sinusoids, large numbers of leukocytes are seen. Conspicuous are large parenchymal cells, many of which are multinucleated; cells are somewhat distorted in shape. The cytoplasm is finely and irregularly vacuolated and yellowish orange pigmentation of the cells can be made out (Fig. 2). In other portions of the biopsy we see more leukocytic infiltration and prominence of bile ducts. No fibrosis is apparent in this section. (Figs. 3, 4, & 5—Higher power, photomicrographs of Figs. 1 & 2.)

Special stains for fat were carried out. Small amounts of fat were demonstrable within the parenchymal cells. No evidence of inclusion bodies were found. Distinct interstitial and periportal inflammation.

The pathologic diagnosis made on these findings is so-called: *Giant cell hepatitis.*

Difficult

This problem of hepatitis in the newborn has received considerable interest in the literature of late. There has been a great deal of difficulty in diagnosing hepatitis in the newborn infant. In part this has been due to the infrequent use of needle biopsy of liver in pediatric practice. Also, liver function studies at times have not presented clear cut profiles defining hemolytic hepatocellular and obstructive type of jaundice. The same problem was observed by our service.

In most instances, the problem of persistent jaundice in the new-

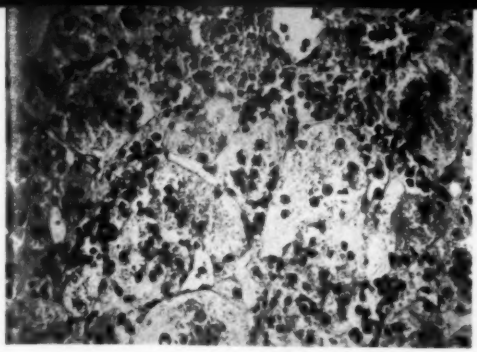


Fig. 3. Higher power — photomicrograph showing hepatic parenchyma.

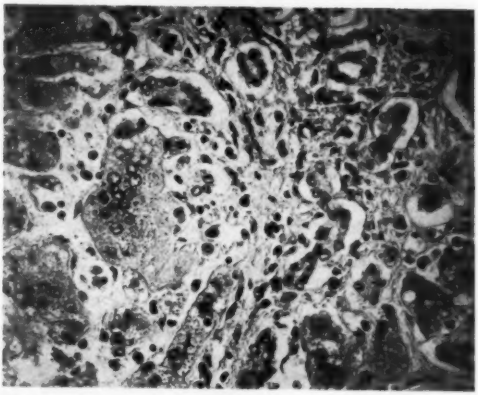


Fig. 4. Higher power — photomicrograph showing periportal spaces.

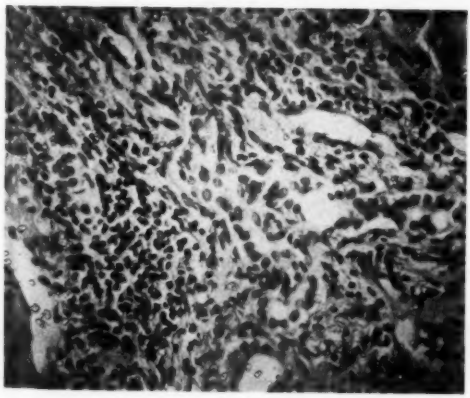


Fig. 5. Higher power — photomicrograph showing periportal space.

born has necessitated surgery to rule out atresia or other developmental anomalies of the bile duct system. As demonstrated very vividly in this case, utilization of transaminase determinations as a diagnostic test, in addition to the increasing use of needle biopsy of the liver in the practice of pediatrics will cut down the number of exploratory laparotomies necessary to establish a diagnosis.

It may be of interest to note this child developed a bowel obstruction and was re-explored on the 7th postoperative day. At this time, lysis of adhesions and a segmental resection of involved ileum were performed. On the 8th day following the second procedure, a wound dehiscence developed. The child expired on the 10th day after the second operation.

At postmortem examination, the liver was found to be jaundiced. The intrahepatic bile ducts grossly appeared normal. Histologic findings were similar to those observed in the surgical biopsy. The entire extrahepatic biliary tree was found to be patent. A bile nephrosis was present with bile casts present within the tubules. The lungs showed focal atelectasis, and a muco-hemorrhagic tracheo-bronchitis was also present. Congenital anomalies were not found in any body system.

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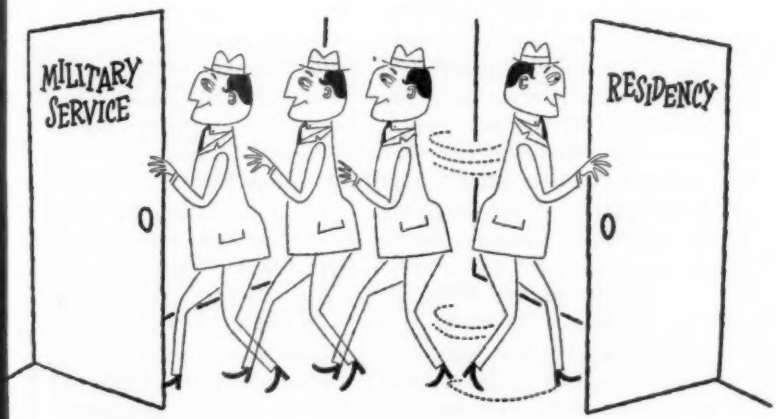
Military Service Now...

The draft law has been extended for four years. The importance of this action on the future plans and careers of thousands of young men studying medicine cannot be overemphasized.



...or Deferment for Residency Training?

The Universal Military Training and Service Act, including the doctor draft scheduled to expire July 1, 1959, was extended to July 1, 1963 by Public Law 86-4.

For the first time since the doctor draft was enacted, the extension is for a four-year period instead of two, and this marks the first extension without substantive change in the law. The Department of Defense strongly supported extension for four years since it believed it would enable both the medical students and the Armed Services to better plan for the future.

As a consequence, all physicians graduating from medical school during the next four years who have a liability for military service are called on to face squarely the question, "Shall I serve now, or chance a draft call later after I have begun residency training or established a practice?"

Each must make up his own mind based upon what appears to be best for him.

Before deciding, however, it is only right that all relevant facts be presented and placed in proper perspective to permit a reasoned, intelligent decision to be reached and a course of action charted.

The information that follows is the best and most current the Department of Defense can provide to assist you in deciding what to do about your military service obligation.

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EATON LABORATORIES, NORWICH, NEW YORK

Prepared in the Office of the Assistant Secretary of Defense (Health and Medical) as an aid to interns in understanding what has come to be known as the "Berry Plan," this article should be read carefully by all house staff who are eligible for military service as doctors under current draft laws. The Editors

was made) the military departments have been able to fill their requirements for medical officers from volunteers. Interestingly enough, for a period of a few months in late 1958, there was a decided decrease in the number of volunteers because of the general knowledge through the medical profession that the law was scheduled to expire July 1, 1959.

Since the first of this year, however, the number of volunteers has picked up and it now appears certain no draft calls will be required before July 1, 1960.

Defense officials point out that this healthy condition, with respect to not drafting physicians, could change overnight if sizable numbers of interns suddenly decide to "let George do it."

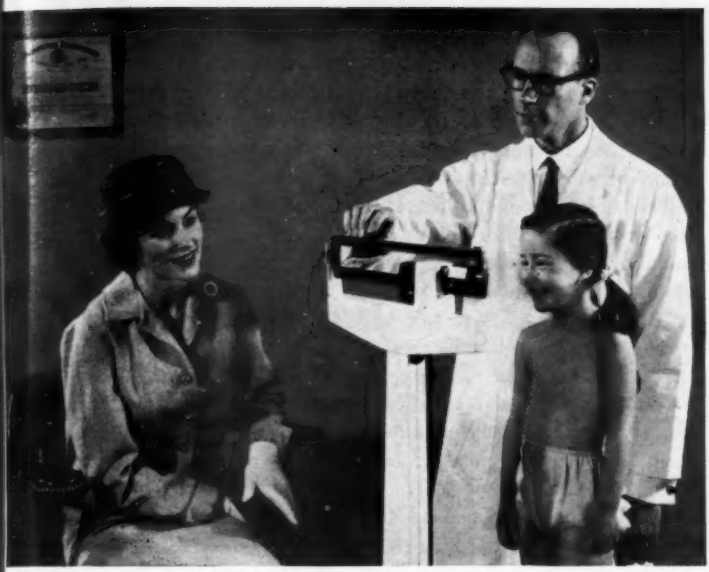
The Defense Department estimates that about 2400 medical officers will be needed during the fiscal year beginning July 1, 1959. Procurement programs will provide the services with about half the requirement. It is hoped the remaining 1200 will be obtained from volunteers through the "Berry Plan," which will be explained in detail in a moment.

Estimate

In fiscal year 1960-61 the Department projects its requirement to be around 1800 physicians. This estimate is based upon the best information currently available. Many factors were considered and evaluated in arriving at this figure. But, as Defense officials point out, any significant change in world conditions could knock the estimate into a "cocked hat" overnight.

There are about 6000 graduates of medical schools in 1959 who are liable for service, and after a year of internship will be subject to being called, on or after July 1, 1960, to active duty in fiscal year 1960-61. Thus, the Armed Forces will require 1800 of the 6000 doctors graduating in 1959 who are liable for military service.

With this knowledge the intern may ask "why should I volunteer when the chance of being drafted is so slight?" This is not an easy answer to come by, since



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Most of the weight gained was not lost after discontinuance of Nilevar therapy although many patients did not continue the sharp gains effected by the drug.

The authors are of the opinion that Nilevar is a highly useful anabolic agent for influencing weight gain in underweight children.

When Nilevar is administered to children a dose of 0.25 mg. per pound of body weight is recommended and continuous dosage for more than three months is not recommended.

Nilevar is supplied as tablets of 10 mg., drops of 0.25 mg. per drop and ampuls of 25 mg. in 1 cc. of sesame oil. Further dosage information in Searle Reference Manual No. 4.

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Research in the Service of Medicine.

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*Brown, S.S.; Libo, H. W., and Nussbaum, A. H.: Norethandrolone in the Successful Management of Anorexia and "Weight Lag" in Children, Scientific Exhibit presented at the Annual Meeting of the American Academy of Pediatrics, Chicago, Oct. 20-23, 1958.

individual circumstances and objectives are seldom the same.

The first decision to be made is whether or not you wish to begin private practice with your military obligation unfulfilled. In this connection, you should remember that in the event of a National Emergency those interns and residents *who have not had military service* will probably be the first called to active duty.

Another important consideration is that interns who take their residency training on their own cannot expect to fulfill their military obligations as specialists after they have completed their residency training, because the Armed Forces in-service career residency training programs and the residents deferred under the "Berry Plan" will provide the specialists needed by the military departments.

Berry Plan

The "Berry Plan" so-called after the Assistant Secretary of Defense for Health and Medical, Dr. Frank B. Berry, is important from the standpoint of both the intern and the Defense Department. The complete story, together with "what, why, who and when," must be fully understood to appreciate the advantages the plan offers to newly graduated physicians who have an obligation for military service.

What is the program?

This is a program developed in 1954 by the Department of Defense, in cooperation with the Selective Service System, to permit physicians who are liable for military service to be commissioned well in advance of the time they will be required to serve, and to permit successful applicants to be deferred for residency training in specialties required by the Armed Forces.

Why is the program important?

The program has several purposes, but the most important features are that first, it permits draft liable physicians to apply for and receive reserve commissions while still in internship so that those physicians who desire to do so may enter on active duty following completion of internship. Second, it permits the physician to express a choice of service (Army, Navy or Air Force) and to indicate the date he would prefer to enter on active duty. The individual preferences will be followed insofar as the requirements of the military departments permit. In the past, the departments have been able to honor over 85 percent of these preferences. Third, the program enables the military services to

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obtain from those physicians obligated for military service the required number of physicians with specialty training.

The intern is given a choice of requesting:

- Deferment for residency training required for board certification.
- Active duty beginning during the year following completion of internship.
- Active duty beginning one year after completion of internship.

Preference for active duty to begin during the year following completion of internship, or one year after completion will be honored on the basis of first come, first served, with the postmarked date of the application for commission being the determining factor.

Unless a desire is expressed to enter on active duty at a later date the majority will be called during July and August. Interns deferred for residency training are expected to begin their military service upon completion of the required training.

Reserved

Vacancies in the military departments are earmarked and rereserved only for residents who complete all of the required training. Residents who voluntarily terminate their training prior to completion of the number of years required for board certification will be brought to duty as vacancies occur. There can be no assurance that they will be utilized in their specialty field.

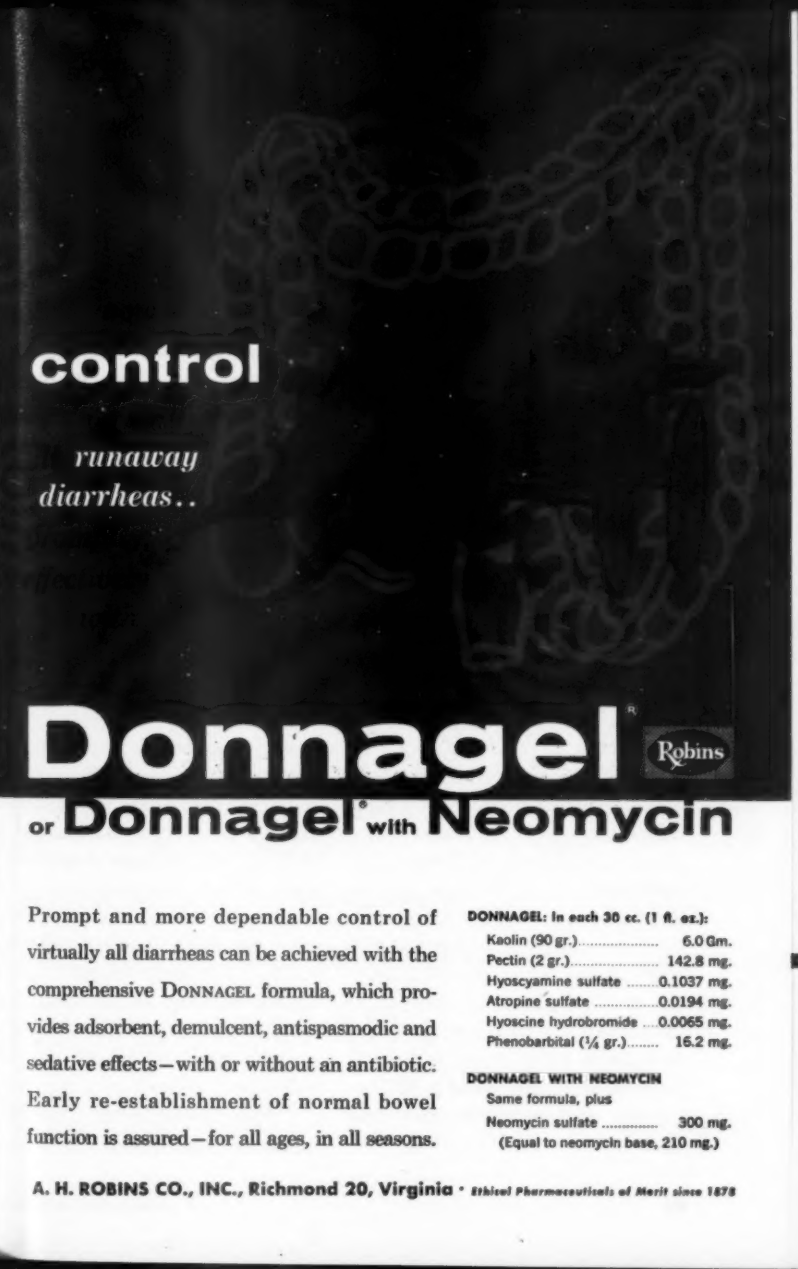
Who may participate?

For commissioning and call to active duty, or consideration for residency deferment, the physician, *in addition to being liable for two years of military service,* must be a 1959 graduate of a medical school approved by the Council on Medical Education and Hospitals of the American Medical Association. He must be qualified for and willing to accept a Reserve commission in the medical corps of one of the Armed Forces.

When must the intern apply?

To participate in the program, the 1959 graduate must complete and mail before September 15, 1959 the Statement of Preference which will be made available in July. (A mailing list for distribution of bulletins and forms will be made up from lists of senior medical students and their internship addresses furnished by the deans of medical schools.)

Failure to meet the deadline will result in the intern being allocated to one of the services for



Prompt and more dependable control of virtually all diarrheas can be achieved with the comprehensive DONNAGEL formula, which provides adsorbent, demulcent, antispasmodic and sedative effects—with or without an antibiotic. Early re-establishment of normal bowel function is assured—for all ages, in all seasons.

DONNAGEL: In each 30 cc. (1 fl. oz.):

Kaolin (90 gr.)	6.0 Gm.
Pectin (2 gr.)	142.8 mg.
Hyoscyamine sulfate	0.1037 mg.
Atropine sulfate	0.0194 mg.
Hyoscine hydrobromide	0.0065 mg.
Phenobarbital (¼ gr.)	16.2 mg.

DONNAGEL WITH NEOMYCIN

Same formula, plus

Neomycin sulfate	300 mg.

(Equal to neomycin base, 210 mg.)

A. H. ROBINS CO., INC., Richmond 20, Virginia • *Ethical Pharmaceuticals of Merit since 1878*

commissioning only, and not being considered for residency deferment.

Preference

In returning the Statement of Preference by the appointed time, the intern has set the wheels in motion. Before deciding whether to apply, however, full information, in booklet form, will be sent to all interns and hospitals by the Defense Department. Close study of the booklet is a *must*.

On July 1, 1959 about 2600 residents will be in a deferred status. Roughly 900 will be in their first year of training and the remainder in the second, third or fourth years.

In the program for 1958 graduates, 1769 applications for active duty or deferment were received by the deadline date. Of 1198 who requested deferment, 937 were selected. There were 452 interns who requested active duty immediately following internship, and 119 who wanted duty one year after completion of internship. An additional 170 applications were received after the deadline; most of these were processed for allocation and active duty—a few requests for deferment were approved to fill vacancies still available in some specialties.

Specialty

The chances of being selected for deferment depend on the number requesting deferment in each specialty, and the total number the Armed Forces require to be trained in the specialty. About 870 will be selected in all specialties.

Each specialty is considered separately and selections for deferment are made by lot from those participants desiring training in that specialty. The selection rate varies considerably between the specialties. Last year it ran from 100 percent for such specialties as anesthesiology, otolaryngology, general practice, preventive medicine, etc., to 77 percent for orthopedic surgery and 60 percent for surgery.

Each year some residents voluntarily request active duty before completion of the training required for board certification, thereby creating a number of vacancies. The military department tries to replace those who withdraw with other residents who have the same level of training. Each department usually has a limited number of vacancies for deferment for residents in their second, third or fourth year of training.

"What advantage do I have if I decide to participate?" is the

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Radiation Proctitis

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Supplied: Suppositories, boxes of 12. Each suppository contains 10 mg. hydrocortisone acetate, 15 mg. extract belladonna (0.19 mg. equiv. total alkaloids), 3 mg. ephedrine sulfate, zinc oxide, boric acid, bismuth oxyiodide, bismuth subcarbonate, and balsam peru in an oleaginous base.

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question many interns may ask.

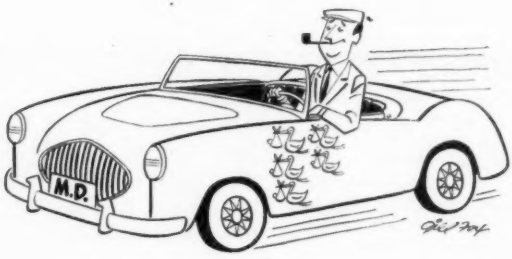
There are several advantages. For those who desire residency training, there is the assurance that if selected, the residency will not be abruptly terminated by a draft call.

For the intern who desires to enter active duty immediately after internship or one year after internship, there is the assurance that he may make plans for entering private practice or residency training after serving, and he will have the peace of mind that comes from the knowledge that he has fulfilled his military obligation and will not be called upon to serve again unless there is a National Emergency.

"What happens if I decide not to participate?" cannot be answered with the same degree of certainty as the previous question. If sufficient interns do not participate and request active duty to meet the needs of the military departments for physicians, a special draft call is the inevitable result. In the latter event, the physician has neither choice of service nor time of entry on active duty. The draft liable physician who has not participated runs the danger of serious financial loss if the military service interrupts his practice for two years. This will continue either until he does serve or until he is 35 years old.

"What is best for me to do?" is the final question. The answer, of course, is up to you. When you receive the information bulletin (as you will) from the Assistant Secretary of Defense (Health and Medical) it will fully explain the program.

It will not answer, however, what you should do, for in the last analysis that decision must be made by you.



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1. Coleman, S. S.: Am. J. Surg. 97:43 (Jan.) 1959.
2. Richardson, M. E.: J. Am. Osteop. A. 57:562 (May) 1958.
3. Mason, M. L.: Northwest Med. 57:1439 (Nov.) 1958.

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Thiamine Mononitrate (B_1)	10 mg.
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Niacinamide	100 mg.
Ascorbic Acid (C)	300 mg.
Pyridoxine HCl (B_6)	2 mg.
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Folic Acid	1.5 mg.
Calcium Pantothenate	20 mg.
Vitamin K (Menadione)	2 mg.

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QUIET, PLEASE!

YOUR WIFE'S TALKING

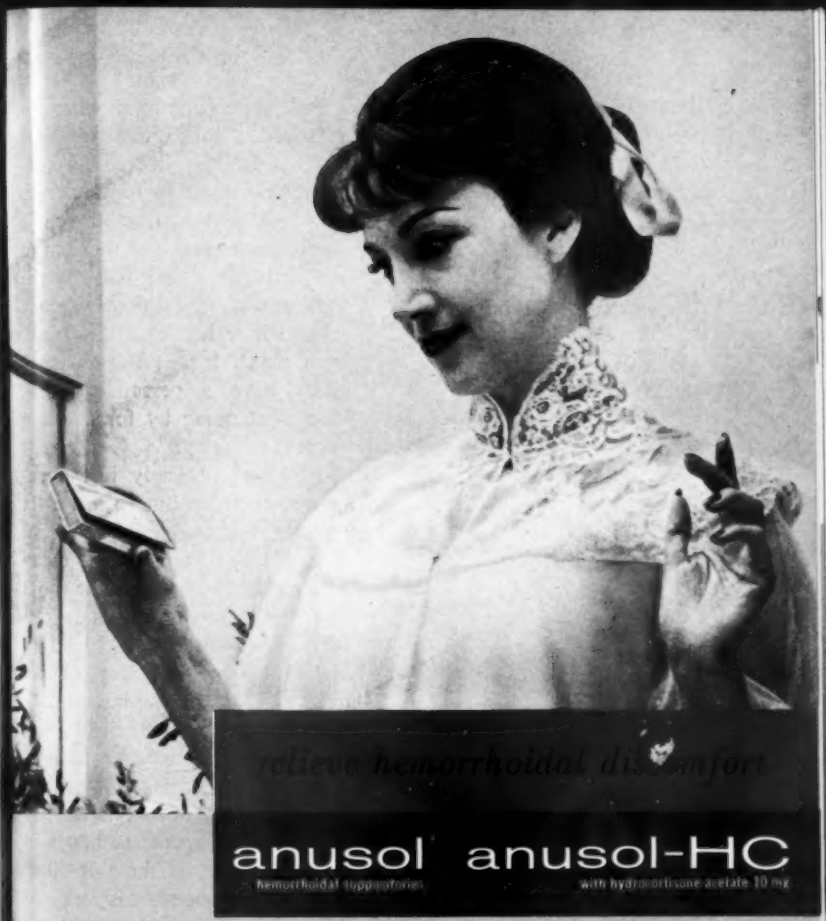
What About Wives' Day at the Hospital?

Why not a wives' day at the hospital? Those opposed to the idea may say that the hospital couldn't condone a practice which might interrupt hospital routine, or that the hospital is too busy to put up with such nonsense. I disagree.

Mrs. Vollrad J. von Berg

In any business or profession the husband is usually proud to show his wife his place of work. Probably few wives are interested enough to be enthusiastic when taken on the guided tour—but I think every woman is interested in seeing where her husband works. As far as physicians wives are concerned I think that there is more than an ordinary interest. Any physician's wife has a certain respect and awe—and a justifiable pride in the accomplishments of her resident or intern spouse.

I am the wife of a resident in surgery. I have never had a tour of his hospital. And I am positive that I share this position with several other wives, thousands of them. That's why I'm suggesting, as the title indicates, a special tour by which house staff wives may see the facilities wherein their husbands accomplish their professional work.



To eliminate anorectal pain and itching during pregnancy, *start* treatment with anti-inflammatory Anusol-HC Suppositories for 3 to 6 days. Then *maintain* patient comfort with regular Anusol Hemorrhoidal Suppositories. Neither preparation contains narcotics nor analgesics, therefore they will not mask more serious rectal pathology.

And for constipation . . . either alone or concurrent with anorectal disorders . . . prescribe pleasant-tasting *Agoral* (described next page).

WARNER CHILCOTT
MORRIS PLAINS, N.J.

It may well be asked what purpose or goal would be served to have a wives' day at the hospital. By what means could it be accomplished? Who would benefit, if anyone?

I think one of the goals to be achieved by such a program is simply to satisfy the wives' curiosity, to see and observe The Place where he spends so much more of his time than he does at home. By this I don't mean the lobby of the hospital or the waiting room. I mean everything there is to see. Perhaps the doctor and his wife would have a closer understanding if she were able to see that operating room where he removed a little girl's appendix that, as she remembered his comment, was about to rupture. And how about the fracture clinic where he set and cast the arm of the little boy who fell off the milk truck. And the emergency room where he put 106 stitches in a man's leg. (And do they really have a person counting stitches standing by for such an event?)

Sure I'm probably just a romantic at heart, but so are a lot of other women.

Another thing almost every wife would like to see is the room where our doctor husbands call us from when they're held up all night at the hospital. I would like to give substance to my imagination and to the image conjured up when he tells me he's been in a particular place for two hours that afternoon. For example, say your husband spent six hours in the OR. What is the OR like? How can you relate his story to this physical thing, this OR? We can all guess, of course. But it would be so much better if we knew and with a tour we would know intimately, exactly.

In explaining this the other day to my husband I told him, "If I tell you I was out picking flowers in the backyard, you can imme-

control constipation safely

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the gentle laxative

Agoral provides the safe, gentle laxative action so desirable in overcoming the constipation of pregnancy. Taken at bedtime, 1 or 2 tablespoonfuls of pleasant-tasting Agoral work overnight, without disturbing sleep, to produce a normal bowel movement next morning. Agoral encourages *natural* bowel function . . . without harsh cathartic action . . . without urgency . . . without anal leakage.

And for hemorrhoids . . . either alone or concurrent with constipation . . . prescribe *Anusol* and *Anusol-HC* suppositories (described preceding page).

WARNER CHILCOTT

MORRIS PLAINS, N.J.

diately visualize our yard because you've seen it, and my experience means more to you than if you had never seen the yard or the flowers. But when you tell me you just came from the OR where such and such happened, I can't visualize your particular OR because I've never seen it. This makes your account somewhat remote, not personal enough to me as your wife."

Another goal that I think would be accomplished by the hospital tour for house staff wives is a better understanding of a doctor's role in a hospital. Like all house staff wives, I guess, I'm still not too clear about all the many things he does. Doctors who have nurses for wives have no problem in getting her to understand what it is he does at the hospital. But just as I am a school teacher, many other doctors' wives have had no association with medicine and medical facilities.

I think a certain amount of confusion results from a wife not fully comprehending her husband's role as a hospital resident. For example, a few nights ago my doctor husband was to come home for dinner. He had been at the hospital for three days and nights, averaging about an hours sleep during this period. About an hour before dinner the telephone rang. No, he didn't say that he wouldn't be home just that he'd be a little late. "I have to go over to the lab and try to balance the output intake of the sigma motor finger pump. See you about 8."

It's the first I'd ever heard of a finger pump or a sigma motor although the words output and intake had come into my vocabulary — though I admit I still don't know what in the world they mean. But this pump, that could be something that might be pointed out on the hospital tour. Even knowing the pump, as I later learned, had something to do with heart operation, is certainly some satisfaction that I didn't have during the telephone conversation. I suppose too, the wife of the urologist would like to have some idea of what an artificial kidney really looks like. These could be pointed out during "Wives' Day at the Hospital."

Having some idea of the various pieces of equipment in the areas of the hospital the various departments would, I think, give a tremendous advantage in our understanding and being more understanding about our husband's ethics in his profession.

Another goal of this program, and no less important than learn-

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ing of the facilities, would be the opportunity to meet the people our husbands work with. Also, it would be nice to meet the other wives — although the latter is usually accomplished through the wives' club or the resident-intern dance once a year. But the next time he mentions his chief or another doctor on his service, you would have some recollection of the person in question. It helps to know.

The actual method or operation of "Wives' Day at the Hospital" are many and varied, of course. However, I think they could be classified in three groups: the formal affair, the informal, and the small group affair.

The formal affair could be likened to the functions arranged by some of the drug companies. At these sessions, the companies invite senior medical students and their wives to a two or three day visit of their pharmaceutical operation to acquaint them with the various medicines and preparation. The wives are treated like queens. They appear happy that the husbands have them along. The wives in turn usually respond with interest and enjoy the tours thoroughly.

Just as the drug companies, through an intelligent public relations approach, have capitalized on the wife's interest and desire to understand something of her husband's work, I think the hospital administration could take a page from the book and follow their fine example. Good will, the wife's good will toward the hospital, is in this day and age an important factor in house staff contentment and piece of mind.

No matter which of the three types of affairs we discuss, first a date and time must be arranged. I think the best date would be about a month after the new interns come on duty, say the first week in August. It should be understood that the affair would be limited to interns and wives, new residents and wives, department heads and their wives, and the hospital director and his wife.

As a woman, of course it might be expected that I would have one of those feminine touches to add to such an occasion. Corsages for the wives would indeed mark this night as an occasion. There would be name tags. There would be a welcoming committee. There would be a brief welcoming speech by the director followed by an introduction of department heads, perhaps a short history of the hospital, followed by the leisurely but planned tour of the hos-

pital facilities.

Since one of the objections to the tour would undoubtedly be that it would interrupt hospital routine, I think that small groups would cause less of a problem in this respect. The various subgroups could make their tours of the hospital in separate directions. Perhaps the residents and their wives associated with a single service might join in the same group and proceed directly to that service followed by a general tour of the other facilities in the hospital.

After a stipulated time, all would return to the original place of meeting for coffee and cookies, a social hour. An informal affair would be similar but could eliminate some of the pomp and circumstance. For example, no corsages, no speeches, no introductions of department heads and no coffee hour. Just a business-like trip with each doctor husband taking his own wife on a personal tour of the hospital. I don't particularly favor the informal type of tour. But it certainly is better than no tour at all. The final possibility would be the small group affair. This could be arranged so that only a certain number would go on tour on any particular evening. This would be done by invitation.

Incidentally, I think it's important to stress that no matter which choice would be favored by your hospital, an invitation should be sent out. The announcement should not be made in hubby's mail box to be lost or discarded by him as he's whipping through his load of direct mail literature. I think wives' day at the hospital would be an annual affair of importance. It would benefit both the hospital, the house staff members, and his wife.

Because the hospital went to the trouble to put on a special affair just for her, the wife would certainly be made to feel a part of the vital hospital family—which she most certainly should be considered. Wives would benefit by having a better understanding of their husbands' responsibilities as well as how the hospital functions. I think it would be a way to gain her loyalty and respect for The Place which is such a rival for her husband's affections. When the orthopedic resident calls his wife to tell her he'll be late because he has to put a new patient in traction, she may not be able to smile. But she can say yes dear, visualize the situation, and understand more fully both the need and the work to be done.

I know this suggestion will

come as a radical innovation to many of the old guard of medicine. Students, interns and residents who aren't supposed to get married at all, according to the old tradition. But I think it's time we faced it. Better than four out of five house staffers are married, most with children. Times have changed and the hospital can no longer afford the luxury of complete remoteness from the house staff's family interests and obligations. I'm sure that the house staff members themselves would hold the entire hospital in higher esteem for having made this gesture of confidence and good will toward his wife, recognizing her as a partner in life and in spirit and in fact in a doctor's profession.

I think all residents' wives can't help at times their feelings of animosity and resentment towards the hospital because of the many hours and almost desperately hard work it sometimes demands of their spouses. It hurts your heart to see your husband shuffle into the house drawn, almost completely exhausted with lines of fatigue drawn sharply on his face. Even with a wives' day at the hospital, I don't believe that wives' hearts will hurt any less when they see their tired husbands return home after a particularly tough day. But I am convinced it would ease the feeling of resentment, an illogical but yet a strongly felt resentment against the hospital.

Now I hope some of you husbands will help by bringing this suggestion before the house staff committee or to your administrators, and try to convince them of the value of taking your wife to see your second home.

EDITOR'S NOTE: *Mrs. von Berg won her point. She has told us that she has had her day at the hospital, even got to see the sigma motor finger pump and the inside of a couple of the ORs. She said it was a short tour and didn't cover everything. But she has been promised she will get to see the hospital again in the near future. If any other wives have comments or suggestions concerning this plan, we'd appreciate hearing from them.*

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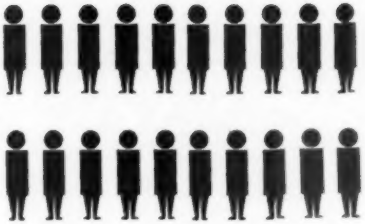

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1. Brit. M. J. 1:407, 1952. 2. Bull. Margaret Hague Mat. Hosp. 1:68, 1948. 3. Am. J. Obst. & Gyn. 57:541, 1949. 4. Connecticut M.J. 14:830, 1950. 5. J.-Lancet 66:218, 1946. 6. Am. J. Obst. & Gyn. 62:947, 1951. 7. Am. J. Med. Sc. 212:76, 1946. 8. Obst. & Gynec. 5:201, 1955. 9. J. Ped. 41:170, 1952. 10. Ann. Int. Med. 42:458, 1955.

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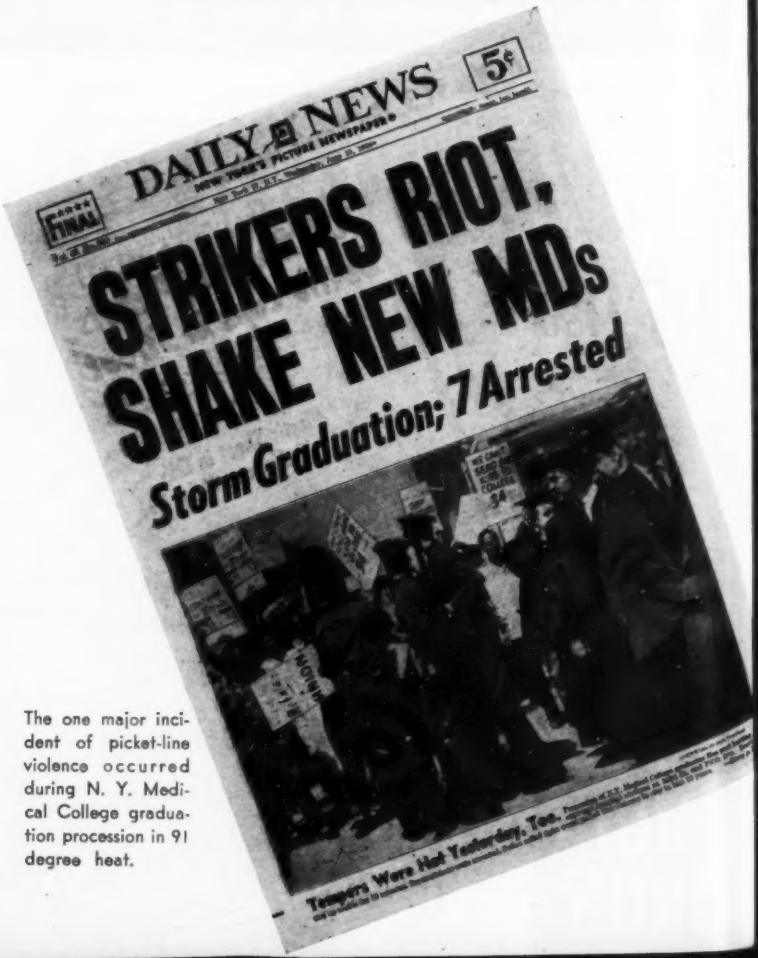
New York City . . .

How House Officers Fa

To find out, RP interviewed residents and interns at the seven struck hospitals . . .



The one major incident of picket-line violence occurred during N. Y. Medical College graduation procession in 91 degree heat.

ers Fared in Hospital Strike

"The first few days were the toughest . . ."

That was the gist of resident and intern reaction to the 45-day hospital strike of nonprofessional workers in New York City which ended June 22.

The walkout involved seven voluntary hospitals, and affected 3,500 cafeteria and laundry workers, elevator operators, nurses' aides, cooks, custodial workers, messengers, animal handlers, orderlies, laboratory helpers and others.

During the closing days of the strike, RESIDENT PHYSICIAN interviewed house staffers in the struck hospitals. How had they been affected?

"At first it was rough. Lab work backed up," reported one medical resident, "and we were told to cut down on lab procedures to the barest minimum. But as people were hired, we began to get back to normal."

In four of the seven hospitals, clinics were suspended or combined.

"Because there were no cleaning people, our diagnostic clinic was closed down and other clinics were combined on one floor to reduce maintenance," one resident reported.

From the house staff point of view, linen seemed to be the number one problem in a number of hospitals. "At first we were terribly short on surgical linens—but gradually this situation was eased when arrangements were set up with other nonstruck hospitals and outside laundries," a chief surgical resident stated.

"Nurses had no O.R. gowns. We were permitted to wear our own clothes with a white coat because we couldn't get our whites," one resident reported.

"Even when we were authorized to use outside laundries, we would get our coats back one day, pants the next. It was pretty fouled up."

How about meals? "About as bad as usual," said one intern with a chuckle. "We had paper plates and plastic tableware at first, and the choice of entrees was limited to a single item for each meal. Breakfast was mostly cold cereal."

STRIKE NOTES

Union recognition was the key issue of this first major hospital strike in New York City's history. As private, non-profit hospitals, administrators claimed they were exempt from state labor act provisions calling for collective bargaining with unions. The hospitals' refusal to recognize the union sparked a bitter dispute. The entire labor movement of New York backed the strikers while the hospitals had the support of the Greater New York Hospital Association of 81 voluntary hospitals. Undertones of racial tension became open charges that the hospitals were exploiting the pool of cheap labor from the slums. Most of the strikers were Negroes and Puerto Ricans. Some who were being paid $34 a week were also reportedly receiving up to $70 a week, depending upon size of family, from city welfare agencies. (The hospitals are exempt from federal minimum wage rate of $1 per hour.) One provision of the strike settlement called for $1 per hour minimum wage. The hospitals had voluntarily increased their wages to this minimum several weeks before the strike was settled.

One resident said his hospital used TV dinners for patients for a few weeks.

Laboratories posed problems in most of the hospitals. In one, chemistries were held up. In another, bloods were the big roadblock.

"Although 7 hospitals were picketed during the strike," one resident said, "there were few incidents that we know of . . . except the one at Flower Fifth." (See picture).

No clashes involving house staffers were reported to RESIDENT PHYSICIAN by interviewed residents or interns. Said one, "We knew many of the people on the picket line. It was embarrassing, in a way, to pass them in the street. They would say 'Hiya, Doctor' in a friendly way. But it was an uncomfortable feeling."

Volunteer workers flooded many hospitals within a few days of the strike's beginning. "They seemed to come out of the walls. It was odd to have a young business executive in grey flannels operating the elevator. They were very polite and friendly—and in many jobs, more efficient than those who had gone on strike . . ." Gradually, volunteers were replaced by new employees.

A native of the Philippines where she attended medical school, the chief medical resident at a midtown hospital said the strike had no effect on her professional duties or personal comfort.

"Actually, the only indications to me that there was a strike was the presence of the pickets out-

PROZINE offers effective aid in the treatment of many organic symptoms arising from moderate to severe emotional disturbance. For example, PROZINE produced improvement in 62 of 74 patients[1] with anxiety neuroses accompanied by nausea, vomiting, tremor, palpitations, or fear. In another 57 patients[2] suffering from nausea and vomiting, PROZINE benefited over 90 per cent.

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1. Case reports on file, Wyeth Laboratories. 2. Parks, R.V., and Moessner, G.F.: Dual Approach to Patient Care, Scientific Exhibit, A.A.G.P., April, 1959.

"Nausea and vomiting? Not any more!"

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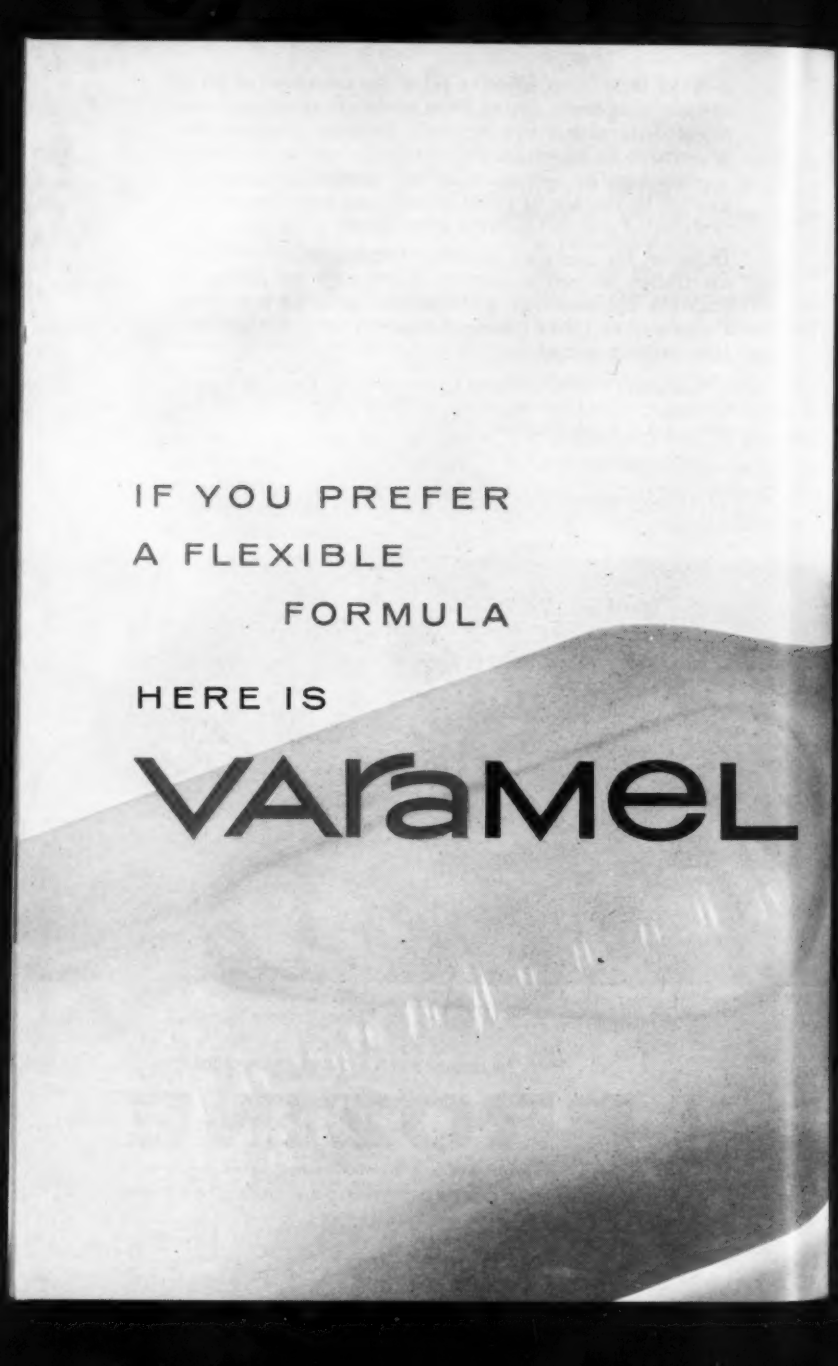

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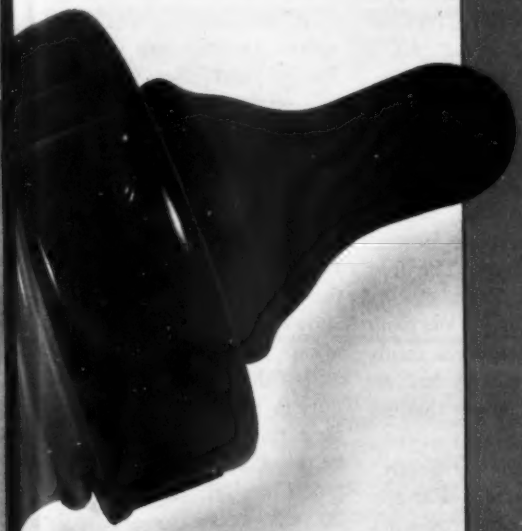

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Vitamin D	400 U. S. P. units
Ascorbic acid (C)	50 mg.
Thiamine (B_1)	0.6 mg.
Niacin	10 mg. equiv.
Riboflavin	1.1 mg.
Vitamin B_6	0.15 mg.
Calcium	900 mg.
Iron	7.5 mg.

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providing all the normal dietary requirements plus a reserve for stress situations.

side, the fact that my uniforms weren't starched enough, and that there was less variety of food in the cafeteria."

Another foreign physician at the same hospital, a resident in obstetrics and gynecology who plans to spend next year at a midwestern training center, echoed the Philippine doctor's views.

"This hospital was hardly affected. All kinds of volunteers—from housewives to businessmen—showed up to help. We had no trouble with laundry, labs or meals. If anything, the meals in our cafeteria were better."

The chief surgical resident at a hospital connected with a medical school felt that "we were lucky that we could call on students to help out. They worked in the kitchen, worked as porters and ran the elevators. The first day they missed floors by six inches, but then they got the hang of it. In the beginning some meals for patients were late by half an hour or so, but I know that no patient suffered."

Was he affected personally? "Not very much, really. For the first two weeks all of us residents had to wear blues—the laundry got behind schedule, so there were no white uniforms available. But that's a minor thing, like the necessity to clean our own rooms and make our beds.

"The important thing is that we maintained a full operating schedule on both ward and private cases. For the first couple of weeks we restricted the number of staff patients admitted. We did this to save bed space in case volunteer workers had to stay over, but this didn't prove necessary.

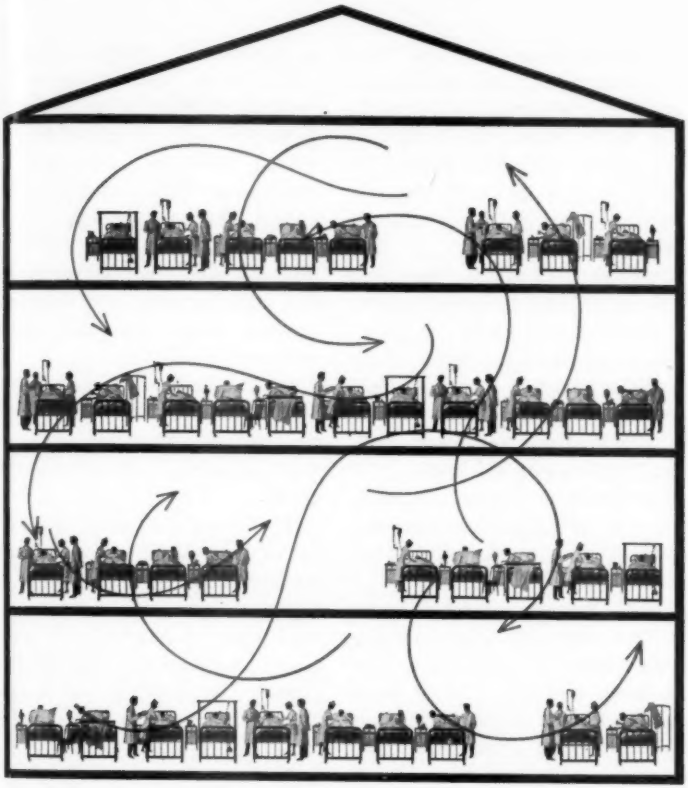
"Taking everything into account, I can't say that we were greatly affected by this thing."

A medical resident who will spend the next two years in the Public Health Service said there was no drop in patient admissions at the 500-bed hospital where he is winding up his second year.

"In fact there never was any talk about limiting admissions. Patient care continued exactly as before, which served to allay the fears of the few patients who showed anxiety about the situation.

"At the start of the strike, off-duty residents, maybe six or eight at a time, would go down and help out in the kitchen, where a pinch was felt at first. We didn't do any cooking — there were plenty of capable volunteers for that—but we washed pots and dishes and cleaned up.

"But there's one thing I think



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I'll always remember, and that's the tremendous and encouraging spirit that was generated throughout the hospital. I'm not the sort of person who gets excited by talk about 'team spirit' and that kind of thing, but I can honestly say I got a lift out of the way everyone pitched in. We could hold out a long, long time against a strike of this kind."

"Nurses bore the brunt of the work," according to one medical resident. "At first the attitude of everyone was very good. Pulling together with a friendly spirit of cooperation. But as time went on, the extra work, inconvenience, clutter, confusion and so forth began to tell on all of us."

Bull sessions among house staffers, of course, concerned the issues involved in the strike. One problem was the $34 a week salary of some of the workers. A resident in pediatrics said: "We kidded among ourselves about going on strike to get a raise to $34 a week." According to this resident, "Most of us were in sympathy with the problems involved on both sides—but on balance, we were pretty generally agreed that the wage was too low for anyone—and also that the jobs involved required more effort and incentive and therefore merited more pay and better workers."

One comment, heard fairly often, was to the effect that "half the workers at twice the pay would accomplish three times the work."

The strike settlement allowed for an increase in pay as well as representation of the workers to negotiate terms, grievances and conditions of employment with a special board created for the purpose. Although union recognition was wanted by the strikers this was not a part of the strike settlement terms.

That the struck hospitals were able to continue providing quality professional care to patients is due in large measure to the extra effort of house officers and nurses. To their credit, these professionals worked efficiently under emergent conditions for more than six weeks. For an extended period of days and nights, residents, interns and nurses demonstrated that their only concern was for their patients.

The fact that the public expected no less than this, in our opinion, is another evidence of the high standards maintained today in American medicine. THE EDITOR.

Mediquiz

These questions were prepared especially for RESIDENT PHYSICIAN *by the Professional Examination Service, a division of the American Public Health Association.*

Answers will be found on page 123

1. Which of the following sets of metabolic derangements occurs in primary hyperparathyroidism with bone involvement?

A) Low serum calcium, high serum inorganic phosphorus and low serum alkaline phosphatase.

B) Normal serum calcium, high serum inorganic phosphorus and high serum alkaline phosphatase.

C) High serum calcium, high serum inorganic phosphorus and high serum alkaline phosphatase.

D) Low serum calcium, low serum inorganic phosphorus and normal serum alkaline phosphatase.

E) High serum calcium, low serum inorganic phosphorus and high serum alkaline phosphatase.

2. The primary defect in erythromelalgia is probably:

A) Thickening of the intima and adventitia of the arteries.

B) Increased tone of cutaneous arterioles.

C) Vascular spasm of digital arteries.

D) A hypersensitive state of cutaneous pain fibers to heat or tension.

E) Vascular spasm of venules.

3. An important point in establishing a diagnosis of anorexia nervosa in females is the fact that:

A) Marked pallor develops in association with the wasting.

B) Vaginal smears are usually normal despite irregular menstrual periods.

C) Intense motor activity accompanies the severe cachexia.

D) The onset is frequently postpartum.

E) The basal metabolic rate is slightly elevated.

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4. A neurinoma commonly announces itself first by:

A) Muscular weakness.
B) Paralysis.
C) Loss of reflexes.
✓ D) Pain.
E) Tenderness.

5. It has been observed that lesions involving the inferior olives produce:

A) Bilateral spasticity.
B) Partial vestibular dysfunction.
C) Bilateral cerebellar asynergia.
D) Bilateral nystagmus.
✓ E) Palatal myoclonus.

MEDIQUIZ REPRINTS AVAILABLE

Through the cooperation of the Professional Examination Service, Division of the American Public Health Association, special reprints of 150 Mediquiz questions and answers are now available in booklet form for $1 per copy. To stimulate further study, the source of each answer is listed in the booklet. The supply of booklets is limited. To be certain you'll have a copy, send your dollar now to the Professional Examination Service, Department R-7, American Public Health Association, 1790 Broadway, New York City 19, New York.

VIEWBOX DIAGNOSIS

(from page 35)

POLYCYSTIC DISEASE

Note numerous masses enlarging and lobing the kidney and producing multiple indentures in the collecting system.

●

MEDIQUIZ ANSWERS

(from page 121)

1 (E), 2 (D), 3 (C), 4 (D), 5 (E).

●

WHAT'S THE DOCTOR'S NAME?

(answer from page 124)

FIELDING H. GARRISON

●

RESIDENT RELAXER

(puzzle on page 39)

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What's the Doctor's Name?

Born in Washington, D. C., on Nov. 5, 1870, he was educated at Dickinson College, taught Latin and Greek, was graduated from law school and served as a Treasury Department auditor for Puerto Rico before he entered the medical profession.

He received his B.A. from Johns Hopkins in 1890 and his M.D. from Georgetown University Medical School in 1893. While studying medicine at Georgetown, he entered the Surgeon General's Library in Washington as a clerk. He was to become this nation's foremost medical librarian and the author of probably the most widely read medical history in the English language.

He soon became assistant librarian at the Surgeon General's Library, a post he held for 40 years, interrupted by 2 years service with the Army in the

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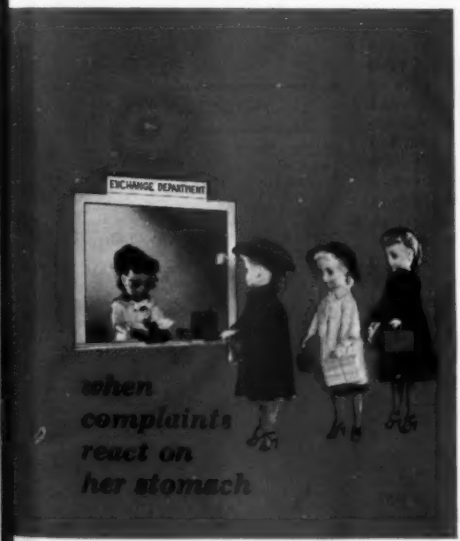
Philippines. In this long career he became editor both of the Index-Catalogue of the Surgeon General's Library and the Index Medicus, the two major indices to the medical literature at the time. He left his Washington position to become Librarian at Johns Hopkins Institute of Medical History in 1930.

His Introduction to the History of Medicine, which appeared first in 1913 and has gone into five editions, is generally considered to be the foremost text on medical history.

From 1906 until his death 30 years later he wrote monographs and articles on medical history, bibliography and biography, medicine in literature, military medicine, science and music.

He was a splendid linguist, an outstanding mathematician and a talented musician. He was completely familiar with ancient and modern literature.

He died April 18, 1935, and was buried at Arlington National Cemetery with full military honors. Can you name this doctor? *Answer on page 123.*



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